

ST. BARTHOLOMEW'S



HOSPITAL JOURNAL

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PRICE NINEPENCE

CALENDAR

Wed., June	1.—Surgery : Lecture by Mr. Vick. Cricket Match <i>v.</i> Horlick's. 2 p.m. Away.	Fri., June	17.—Prof. Christie and Prof. Paterson Ross on duty. Medicine : Lecture by Dr. Graham.
Fri., "	3.—Dr. Chandler and Mr. Roberts on duty. Medicine : Lecture by Prof. Christie.	Sat., "	18.—Cricket Match <i>v.</i> M.C.C. 11.30 a.m. Home. Last day for receiving other matter for the July issue of the Journal.
Sat., "	4.— Cricket Match <i>v.</i> Past. 11.30 a.m. Home.	Mon., "	20.—Special Subjects : Lecture by Mr. Higgs.
Mon., "	6.—Cricket Match <i>v.</i> Croydon. 11.30 a.m. Away.	Tues., "	21.—Dr. Chandler and Mr. Roberts on duty.
Tues., "	7.—Dr. Gow and Mr. Vick on duty.	Wed., "	22.—Surgery : Lecture by Mr. Vick.
Wed., "	8.—Surgery : Lecture by Mr. Wilson. Cricket Match <i>v.</i> Guy's. 11 a.m. Away.	Fri., "	24.—Dr. Gow and Mr. Vick on duty. Medicine : Lecture by Dr. Chandler.
Fri., "	10.—Dr. Graham and Mr. Wilson on duty. Medicine : Lecture by Dr. Evans.	Sat., "	25.—Cricket Match <i>v.</i> St. George's Hospital. 2 p.m. Away.
Sat., "	11.—Cricket Match <i>v.</i> Hampstead. 2 p.m. Home.	Mon., "	27.—Special Subjects : Lecture by Mr. Sidney Scott.
Mon., "	13.—Special Subjects : Lecture by Mr. Bedford Russell.	Tues., "	28.—Dr. Graham and Mr. Wilson on duty.
Tues., "	14.—Dr. Evans and Mr. Girling Ball on duty.	Wed., "	29.—Surgery : Lecture by Prof. Ross.
Wed., "	15.—Surgery : Lecture by Mr. Roberts. Cricket Match <i>v.</i> Richmond. 11.30 a.m. Away. Last day for receiving letters for the July issue of the Journal.		

EDITORIAL

THE TREASURER'S REPORT FOR 1937

AMONG the lay public we are reputed a rich Hospital. On more than one occasion I have known people refuse to support us on that ground. Since then I have always wanted to know how we make our money and how we spend it—how much, in fact, we depend on sporadic charitable gifts rather than on an assured and steady income.

The Treasurer's Report has the answer to all these questions, and to many others besides. Who, for instance, knew that we drank 67,660 gallons of milk last year, which was 13,000 gallons less than in 1936,

owing to the increased use of dried milk in cooking ? And it is quite inspiring to be told that 38,322 articles are washed each week by the Hospital Laundry at a cost of 7s. 5d. a hundred ! Someone can calculate the length of the Hospital clothes-line.

The Report is extremely comprehensive, and there are few aspects of the Hospital administration which it does not touch.

Expenditure exceeds income by £13,195 1s. 7d. This means one of two things ; either that we are wasteful, or that the nature of our work imperatively demands more money. Our own experience and

Mr. George Aylwen's remarks at the beginning of the Report settle the charge of waste: "One realizes that to be a conscientious beggar the cause must be beyond reproach, and so far as in me lies I am determined that Bart.'s shall be in this category. Strictest economy commensurate with comfort and efficiency must be the slogan." We are rich in that we handle big money, but poor in that it is not enough for the great work we have in hand.

Before setting out the statement of the Hospital accounts it may be well to emphasize that these have nothing to do with the Medical College. The College is financially quite distinct from the Hospital.

The income of the Hospital, which amounted to £230,689 17s. 5d., comes from two main sources. Over 50% of it is "Invested Property", and approximately 25% is provided by the patients themselves. The remaining 25% is accounted for by charities of one form or another. The Invested Property is made up largely of estates in London (partly by leasehold and yearly premises, and partly by small house properties, of which there are 715), and dividends. In this connection it is interesting to see that the Hospital receives rent from both the Medical College and the Catering Company. There is an increase of £18,445 18s. 1d. in the income of 1937 over that of 1936, corresponding with a rise of legacies.

The Expenditure Account is on the whole very much as the uninformed person might expect. Most goes on salaries and wages, while the next most expensive items are domestic, the Surgery and Dispensary, and provisions. The year shows a net expenditure increase of £29,506 18s. 5d. on 1936. This is accounted for by the opening of the new Medical Block and by certain non-recurring expenses, such as the renewal of the internal telephone, alterations to Casualty Block and temporary accommodation for additional nurses.

In a Report so full of interesting material it is difficult to single out any one particular subject for comment. However, the vicissitudes of the reconstruction scheme and the forthcoming improvements in the conditions of nursing are more than ordinarily important.

The Nursing problem is tackled boldly and energetically. "The Nursing Staff—of whom we are so justly proud—are still overworked in spite of many alleviations in working hours during the past few years, and as this state of affairs is not good for institution or individual, the Treasurer and Almoners have decided to reduce still further their hours of duty. The cost of this concession will be approximately £4000 a year, but it is one which can no longer be avoided. The appointment of additional nurses, which this will involve, makes it still more imperative that the provision of further accommodation for the Nursing Staff must be immediately considered."

At the moment the *authorized* number of the Nursing Staff totals 504, though this figure will not be reached till next October.

In view of the general shortage of nurses it is encouraging to know that there were 1150 applicants for the Hospital's Rules and Regulations of training during the year. Of these, 166 were interviewed by Matron, and 134 finally accepted.

The Paying Patients' Block has been having a very stormy passage. When the scheme was first started, it was decided to ask Parliament for permission to use both Hospital land and money from the general funds to build the block. In 1935 a Private Bill was passed by Parliament which allowed the Governors to use Hospital land for this purpose, but not Hospital money. An attempt was therefore made to raise the necessary sum as a special fund. By private appeal £10,195 was collected—a public appeal was out of the question owing to other more urgent needs. This amount being so inadequate, a fresh Bill was deposited with Parliament last year to enable the Governors to use the Hospital funds. However, the Court of Governors have now been informed that this measure will be opposed by both the Attorney-General and the Clerk to the Crown. The matter has therefore been referred back to Sir Lynden Macassey, K.C., for his further advice.*

Other aspects of the reconstruction scheme are more cheerful. Mr. Lodge's ground plan for the East and West Blocks has been approved, and a

* NOTE.—Since going to press we learn that the Bill has been rejected by a Select Committee of the House of Lords.

detailed plan of the West Block has been submitted to the Medical Council. Mr. Lodge has also been asked to consider the future enlargement of the Surgery. The cost of building a Preliminary Training School for nurses on a site in Cock Lane has been investigated. Tenders showed that this would prove a very expensive business, so the matter has been deferred, though in his Report the Treasurer emphasizes the urgency of its speedy realization.

In an article of this length it is impossible to do more than indicate some of the more interesting features of the Treasurer's Report. We would strongly recommend our readers to turn to the original booklet and discover for themselves how the Hospital is run at the present, and also to learn some of the improvements which our Governors are trying to bring about for the future. The Treasurer is to be heartily congratulated on his first Report.

CURRENT EVENTS

LORD HORDER'S PORTRAIT

The fine picture by Sir William Nicholson of Lord Horder, which we reproduce in this number of the JOURNAL, was presented to Lord Horder by Lord Stanmore, late Treasurer of the Hospital, on View Day. It was paid for by the subscription of 380 old Bart.'s men. The portrait was then given to Mr. George Aylwen for hanging in the Great Hall.

TWO HONOURS FOR BART.'S

Professor Hamilton has won the Neill Prize and the gold medal of the Royal Society of Edinburgh. The medal is only awarded biennially so this is a particularly notable achievement.

The other distinction has been gained by Sir Walter Langdon-Brown, who has been appointed by His Majesty's Privy Council as one of their nominees on the Council of the Pharmaceutical Society of Great Britain.

THE ASSOCIATION OF SURGEONS

Early in May the Association of Surgeons was entertained by the Surgical Staff of the Hospital. A very varied fare was provided for them. Demonstrations included a case of unilateral cervical sympathectomy, conveniently sweating heavily on his normal side, and some fine radiographs of obliterated arteries in the lower limbs, over which Mr. A. M. Boyd was presiding. Downstairs Dr. A. W. Spence was surrounded by a crowd of small boys whose testicles he had persuaded to visit their scrotal sacs. The middle floor was held by Dr. G. Bourne and Mr. J. E. H. Roberts, who were showing cases of omentopexy and total thyroidectomy for heart conditions.

Visits were also paid to the various theatres where some of the largest lists ever posted were being tackled,

and finally the visitors were given a much needed cup of tea in the Great Hall by the Governors.

BART.'S ART

As we go to press there is a neat little pile of entries for our exhibition: a nucleus at least. And it is hoped that the next fortnight may produce many more. It is no good for us to exhort our artists to further efforts because, by the time this appears in print, sending-in day will have come and gone. But we are going to be bold enough to announce that the exhibition will open on Monday, June 13th, in the Great Hall, and will remain open for one week. Admission will be free, of course. Not unnaturally, water-colours predominate, and, at present, no one has been bold enough to submit anything "plastic". Nor is there anything which could be accused of being modern, and it looks, in fact, as if "G. F." will once more be able to exclaim in these columns, "What traditionalists these doctors are!" But it would be rash to prophesy too soon. Who knows, the next few days may witness the arrival of any number of problem pictures. Let us hope they may be clearly labelled "This way up".

FLAG DAY

The result of the collection in our area was a great success. £1,485 was collected, which is an improvement of £449 on last year's effort.

We are told that Lord Horder thinks medical students undignified when they indulge in this pastime. For ourselves we have still to meet the dignified student of medicine. At all events it proved an entertaining day for those of us who were content to throw dignity to the winds and blackmail the public into buying flowers. We are glad that it also proved profitable to the Hospital.

THE SMITHFIELD MARTYRS

We are reminded of a dark period in our national and local history by a ceremony which took place recently on the north wall of the Hospital.

A tablet, surrounded by some iron-work flames, commemorates sixty-six men and women who, between the years 1401 and 1558, were burnt alive in the vicinity of Smithfield.

Mr. W. McAdam Eccles spoke at the unveiling of the restored memorial and pointed out that the present foundation of the Hospital dated from this time.

We hope to publish next month the findings of an inquiry into the details and circumstances relating to these incendiary celebrations.

INFLUENZA REPORT

Those students who offered themselves as experimental animals to the influenza workers will be interested to hear that the results of this work have been published.

The Report is called *A Study of Epidemic Influenza with Special Reference to the 1936-7 Epidemic*, by C. H. Andrewes, and E. G. H. Cowen; and D. K. M. Chalmers, E. G. H. Cowen and D. L. Hughes. It is obtainable from the Stationery Office in Kingsway, price 2s. 6d. The Report will have a full notice in our Review Columns.

THE DECENNIAL CLUBS

The Annual Dinner of the SEVENTH DECENNIAL CLUB will be held on the first Wednesday in July—the 6th.

Notices will be sent to all members in due course and to all belonging to the Sixth Club who can be traced. These gentlemen are cordially invited to regard themselves as members of the Seventh, and to attend the gathering at the Trocadero Restaurant.

The Annual Dinner of the EIGHTH DECENNIAL CLUB will be held at the Langham Hotel at 7.30 on Wednesday, July 6th.

The Rt. Hon. Lord Addison, P.C., will be in the chair.

The Hon. Secretaries are Sir Walter Langdon-Brown and Sir Charles Gordon-Watson, who hope that members resident in London will be good enough to offer hospitality to old friends who are members living in the provinces.

The Dinner of the NINTH DECENNIAL CLUB will be held at the Langham Hotel on Wednesday, July 6th, at 7.30 p.m. The Secretaries of this Club are Mr. R. C. Elmslie and Mr. C. M. Hinds Howell.

At the second dinner of the TWELFTH DECENNIAL CLUB Dr. C. Barrington Prowse was in the chair. Of the 1300 doctors who were invited to dine some 68

turned up, and this may perhaps have been due to the fact that the invitations specified neither time, place nor attire. The majority of the faces were familiar but belonged more to the beginning of the era than to the end of it. Indeed the attendance of junior members of this club was lamentable—no less. As for the evening, the opinion generally held was that the company was good, the speeches poor, and the dinner itself (considering the place and price) should have been better. But we chose some very good wine, and returned to share the Secretary's hospitality in Surgery House.

In the article on "Students' Physical Welfare", which was in the JOURNAL for April, we regret that there was a mistake in the date on which it was made compulsory for students entering the Hospital to join the welfare scheme. This was stated to be October, 1938, and should read October, 1937, this being the date on which the entrance fee was raised from £10 to £15.

BRITISH MEDICAL ASSOCIATION

The Annual Meeting of the Association, which is the hundred and sixth to be held, is this year to take place at Plymouth on July 19th-22nd.

Following is a list of Bart.'s men taking part :

Section of Medicine.

T. H. G. Shore	.	.	.	President.
E. A. Roper	.	.	.	Vice-President.
A. W. Spence	.	.	.	Hon. Secretary.

And taking part in the discussions :

E. R. Cullinan	(Wednesday, July 20th).
Sir Walter Langdon-Brown	(Friday, July 22nd).

Section of Surgery.

H. G. Pinker	.	.	.	Vice-President.
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And taking part in the discussions :

A. M. Boyd	(Wednesday, July 20th).
G. L. Keynes	(Thursday, July 21st).

Section of Orthopaedics and Fractures.

N. L. Capener	.	.	.	Vice-President.
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And taking part in the discussions :

N. L. Capener	(Wednesday, July 20th, and Thursday, July 21st).
D. G. Kersley	(Thursday, July 21st).
W. D. Coltart	(Thursday, July 21st).
H. J. Seddon	(Friday, July 22nd).

Section of Neurology and Psychological Medicine.

Taking part in the discussions :

Geoffrey Bourne	(Thursday, July 21st).
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THE RIGHT HON. LORD HORDER, G.C.V.O., M.D., F.R.C.P.

After the painting by Sir William Nicholson.]

Section of Ophthalmology.

Taking part in the discussions :

- J. A. Nixon (Thursday, July 21st).
 C. M. Hinds Howell (Thursday, July 21st).
 A. L. Chandler (Friday, July 22nd).
 N. L. Capener (Friday, July 22nd).

Section of Pathology, Bacteriology and Immunology.

- M. H. Gordon President.
 J. O. W. Bland Hon. Secretary.

Section of Pharmacology, Therapeutics and Anæsthetics.

- Prof. A. J. Clark President.
 J. W. Trevan Vice-President.

Section of Physical Medicine and Physical Education.

- G. D. Kersley Hon. Secretary.

Section of Physiology and Biochemistry.

- T. S. Hele Vice-President.

Section of Radiology.

- W. M. Levitt Vice-President.

Taking part in the discussions :

- W. E. Lloyd (Wednesday, July 20th).
 C. S. Lane Roberts (Thursday, July 21st).

Section of Tuberculosis.

- F. G. Chandler Vice-President.

Section of Oto-Rhino-Laryngology.

- Cyril Prance President.
 C. Hamblin Thomas Vice-President.
 N. A. Jory Hon. Secretary.

Section for the Services.

- Col. E. G. S. Cane Vice-President.

Section of Medical Sociology.

- Egbert Morland Vice-President.

NEWS FROM OUTSIDE

"For all practical purposes British law is powerless to prevent any person from procuring any drug, or making any mixture whether potent or without any therapeutic activity whatever (as long as it does not contain any scheduled poison), advertising it in any decent terms as a cure for any disease or ailment, recommending it by bogus testimonials and the invented opinions and facsimile signatures of fictitious physicians, and selling it under any name he chooses, on the payment of a small stamp duty, for any price he can persuade a credulous public to pay."

With this quotation from the report of a Select Committee on **Patent Medicine** (1914) Prof. Clarke opens his book, *Patent Medicines*. Those of us who have

sought to satisfy the examiners with the help of Prof. Clarke's text-book of Pharmacology have come to expect something more than mere information. Here we have a complete revelation of a most notorious traffic hedged around, to quote the High Court commenting on the law which it has to administer, with "a mass of confused and obsolete verbiage".

Prof. Clarke recounts the misfortunes which have befallen attempts at reform. The Government inquiry of 1914, which worked for two years on its report, published it on the unfortunate day of August 4th of that year. The last Bill in any way attacking the frauds of patent medicine vendors was counted out on the day of the Grand National in 1936, while a vast number of members were enjoying that spectacle. Then some account is given of the blackmail which quack remedy merchants levy from newspapers which would seek to expose them—their weapon is merely to withdraw their advertisements, which, in one case last year, amounted to 26% of all the advertising matter carried by a national daily paper.

No one can neglect this book, and it is published at sixpence.

The general reshuffle and briskening of the Cabinet may well lead to some re-arrangement of **Air Raid Precaution** plans, which remain sadly vulnerable. Gas is perhaps the least of the dangers which civilians may encounter from the air, and the 2s. 9d. civilian mask without outlet valve is not much protection. The subject of rearmament is controversial, but on A.R.P. in Bart.'s there can be only one opinion, and that is that only the best is good enough. In any plan for the safety of our patients and the continuance of our service so vital to the commercial nerve centre of the Empire and its workers, the authorities should be able to rely upon a body of thoroughly trained personnel. Some of the big companies in the area which Bart.'s serves have their casualty clearance schemes already under way. It is to our Hospital that they will come, and the duty firm will find itself working under conditions of some difficulty. It is our business to anticipate these difficulties, and, in so far as is possible, to organize against them.

In conversation with two of the senior staff we had occasion to refer to certain peculiarities of pathological technique observed in the P.M. room of a Hamburg hospital. Briefly the scene is a routine P.M.; the chamber is empty save for the corpse. The attendant arrives, unlocks a cupboard, lays out the instruments, selects a knife and makes the skin incisions, cuts the ribs. Two clerks

arrive, the attendant immediately falls in at the head of the table, three arms rise—"Heil Hitler!" The clerks delve around, causing the incision to fall apart somewhat. Two pathological assistants arrive, the clerks fall in in front of the attendant, five arms rise—"Heil Hitler!" The assistants deliver the organs and arrange them upon a wooden tray; then the chief assistant pathologist enters, the assistants fall in in front of the clerks, six arms rise—"Heil Hitler!" The chief assistant pathologist opens the organs, displaying their lesions to the best advantage. Herr Professor followed by a boy wheeling a dictaphone comes in, the chief assistant pathologist falls in in front of the two assistant pathologists, seven arms rise—"Heil Hitler!" Herr Professor now dictates in a manner incisive and direct his findings, and to complete the scene the rubric must be read in the reverse order.

Sitting by the side of the Fountain the senior medical member of the trio queried "And the corpse, Heil Hitler, his arm was raised in *rigor mortis* too?"

ABERNETHIAN SOCIETY

SIR JOSEPH BARCROFT addressed the Society on May 5th on "Everest in Utero: or how the Rabbit brought forth a mountain". He described in most amusing fashion his own researches into the oxygen dissociation curve of hæmoglobin at various altitudes, both on mountains and inside gas chambers, laying stress on the mental changes which arise from anoxæmia, and the mechanism of acclimatization. He then went on to show that the foetus in utero was about as poorly off for oxygen as a climber on Everest. Towards the end of intra-uterine life the anoxæmia became acute, and might result in the overcoming of inhibition in the central nervous system which left the foetus quiet. The resulting movement might set off parturition.

Prof. CHRISTIE, speaking for the first time in the Bart.'s Lecture Theatre, proposed a vote of thanks.

IN MEMORIAM.

Best I used to love the creak of saddle leather

As the steaming horse turns back for home;

Bleat-like drumming of the sudden snipe,

And the smell of sodden chestnut leaves

Which lie all flecked with gold by mud and rainy weather.

But in those days I had not seen the joy of Death,

Nor glow of autumn tinted ulcers

Veiled by milk white tide of Unna's paste;

Never heard a gentle Hebrew voice;

My coltish fancy not yet turned to C.S.F.

E. M. E. B.

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OBITUARIES

DR. HARRY STARK, who died at the Royal Northern Hospital on April 19th, 1938, aged 33, attended St. Bartholomew's as a student from January, 1924, until 1929. He was in practice in Stoke Newington at the time of his death, and it was my privilege to be associated with him from time to time in his work. He was a man who upheld the best traditions of St. Bartholomew's. He was invariably exceedingly careful, most conscientious and most self-sacrificing. It was never sufficient for him to receive a mere statement of opinion with regard to a case; his practice was always to explore by intelligent cross-questioning every possible avenue which might lead to some satisfactory result, either in reference to diagnosis or to treatment. It was impossible to work with him without being stimulated by his keenness and his unselfish desire to get the best results for his patient.

It is an interesting commentary upon the state of present-day civilization to realize that in certain European countries, a man of his nationality would have been prevented from employing his really great personal and professional gifts in the service of humanity. He leaves a wife and three young children, to whom sincere sympathy is offered.

G. B.

We regret to announce the death of Mr. PERCY FURNIVALL, F.R.C.S., Consulting Surgeon to the London Hospital, aged 70. He was educated at University College, London, and then he came to Bart.'s. In 1896 he won the Jacksonian Prize of the Royal College of Surgeons, and in 1901 he was Hunterian Professor in Pathology and Surgery.

Mr. Furnivall was short distance amateur champion bicyclist and tricyclist for 1885 and 1886.

It is with much regret that we announce the death of FRANCIS JOHN SHEARSMITH BAKER, in India, on May 4th, 1938.

He came to the Hospital in 1929 and qualified in 1936, subsequently holding a House Appointment at the Metropolitan Hospital for six months. He joined the R.A.M.C., and distinguished himself by winning the Gold Medal in Tropical Diseases.

As well as being a keen student, he took an active interest in games, having played rugby for the Hospital XV on numerous occasions.

CARBUNCLE OF THE KIDNEY

By H. L. M. ROUALLE, M.R.C.S., L.R.C.P.

TO many readers, if the term "renal carbuncle" conveys any image at all, it is probably that of the solitary specimen now in the teaching collection of the College Museum, for this condition is not described in any great detail in the ordinary textbooks of surgery or pathology. Doubt has even been expressed as to whether it really exists as a clinical entity; the fact that a second specimen has now reached the Museum with a history in many ways similar to that of the first appears to be sufficient justification for placing both of them on record, particularly as the study of them is interesting and instructive.

The comparative rarity of the condition is shown by the fact that the first example dates back to December, 1933, and no other appears to have occurred in the Hospital until February, 1938. Consequently some time elapsed in both before the final diagnosis was reached, but on each occasion it was made before operation on the history with the clinical and radiological evidence.

The earlier example will be described first, although in some respects it is atypical:

No. 1.—Joseph M—, a painter's labourer, æt. 33, was admitted on December 21st, 1933. He complained that seven weeks previously he had had a gradual onset of persistent and severe, but not colicky, pain in the left side of the back, worse on respiration and movement. There were severe night-sweats and malaise. Pain extended from loin to upper ilium but did not radiate; it was accompanied by a persistent dry cough. Temperature was swinging between 100° and 104°, pulse 90 to 30 per minute. Urine contained only occasional pus-cells and was normal in quantity. Blood-cultures were negative, leucocytes 15,000 per c.mm.

Apart from signs at the base of the right lung, no definite abnormality was discovered till a swelling was palpated in the left loin, moving on respiration.

On transfer to the surgical ward the patient appeared ill, flushed and in pain; the mouth, heart and lungs appeared normal; there was no sign or history of any skin lesion.

Examination of the left loin revealed tenderness on deep palpation; the kidney could not be felt from in front, but posteriorly a mobile swelling could be felt moving up and down on deep inspiration. This swelling was large, its surface smooth, but its outlines could not be clearly defined; the overlying skin showed no redness or œdema, the anterior abdominal wall no rigidity, but the muscles of the loin were tense.

Urine was clear, with a mild trace of albumen; a few white blood-cells could be seen in the centrifuged deposit, but no red cells or organisms. Cultures were sterile.

Plain X-rays showed no abnormality. Intravenous pyelograms were somewhat indefinite, but showed good excretion from both kidneys. The left pelvis appeared smaller than the right, and its calyces spread out in Y-shaped formation. This widening of the calyces suggested the diagnosis of renal carbuncle.

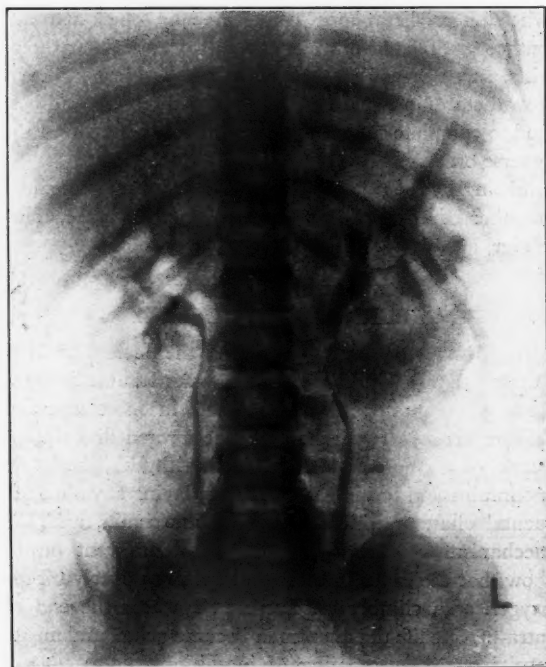


FIG. 1.—Mary L—, intravenous pyelogram (18.ii.38).

Owing to the patient's condition, retrograde pyelography was not performed.

Exploration of the loin revealed marked œdema of the muscles. On cutting into the perinephric fascia a small collection of pus was found outside the kidney near the lower pole; there was an obvious connection with a leaking area in the kidney. A tube was left from the abscess-cavity to the surface.

The pus grew a pure culture of *Staphylococcus pyogenes aureus*.

Renal function tests proved satisfactory and the patient's clinical condition improved, though the temperature remained unaffected by the drainage of the perinephric abscess. It was therefore decided to carry out nephrectomy.

The original wound was reopened, and the kidney

separated from the tissues by flavine swabs. It was two-and-a-half times normal size, and removal was difficult, the peritoneal cavity being opened at one stage. A flavine pack was left in the wound and a 300 c.c. blood transfusion given. Plugging was removed on the fourth day and the wound partially sutured.

On the tenth day a second 300 c.c. blood transfusion was given; convalescence was at first slow but uneventful till the twenty-first day, when the patient developed acute retention of urine, and a week later a prostatic abscess, which necessitated perineal drainage. The pus from this abscess grew a pure culture of *Staphylococcus pyogenes aureus*. The patient then rapidly recovered and was discharged on March 1st, 1934; he has remained in perfect health ever since.

The kidney (TC. D 22) is about two-and-a-half times as big as normal. Occupying the central third is an apparent tumour, projecting from the posterior surface and raised from it; in many places it is umbilicated. At one point there is a deep furrow into the tissues from which could be squeezed, as from a sponge, pus infected with *Staphylococcus pyogenes aureus*. On section, the upper and lower poles appear to be quite normal; the pelvis is spread out in the fashion suggested by the pyelogram in much the same way as is seen in hypernephroma. The affected area is surrounded by a dense fibrous layer; the interior is composed of multiple loculi filled with pus, and resembles the honeycombed appearance of actinomycosis, but the ray fungus has not been found. The swelling is quite firm, but on microscopic examination is found to consist of multiple abscess formations surrounded by fibrous and granulation-tissue.

No. 2.—Mary L—, a rosy-cheeked, plump little girl, æt. 11, came up to the Out-Patient Department on September 4th, 1937, with a large axillary abscess, on account of which she was admitted to Radcliffe Ward. The abscess was drained and several ounces of thick pus evacuated, from which *Staphylococcus pyogenes aureus* was cultured. Temperature, at first $104^{\circ}8'$, pulse 128 per minute, fell steadily, till on September 10th both were normal. Progress was uneventful till September 14th, when the temperature began to rise to 100° and pulse to 90 to 100 per minute in evenings without any obvious cause, until on September 20th the patient first complained of sharp pain in the left loin. The urine was free of albumen or pus, but on culture produced a profuse growth of *Bacillus coli*. Despite the administration of urinary antiseptics, the temperature continued to swing. On September 25th it swung from $98^{\circ}0'$ to 104° , and the tenderness in the loin became so marked that perinephric abscess was suspected. Blood-culture was sterile. On September 29th the urine

produced no appreciable centrifuged deposit, but both coliform organisms and staphylococci were cultured.

The leucocyte count, 7800 on the 26th, rose on the 29th to 14,700 and maintained that level.

The local signs were: pain and rigidity in the left loin, the contour of which was filled out in comparison with the right; absence of superficial tenderness, but marked tenderness on deep palpation; and no œdema, either superficial or deep. Owing partly to muscle spasm the kidney was not palpable, nor was any movement to be detected on inspiration; a certain amount of thickening could, however, be made out in the renal area.



FIG. 2.—Mary L—, left kidney (removed 24.ii.38).

Exploration of the loin was decided on and carried out by the usual incision. The superficial tissues appeared normal, but around the lower pole of the kidney was a small area of œdema. No pus was found, and as the organ itself felt perfectly normal on palpation, the wound was closed round corrugated rubber drains.

Following the exploration of the loin, the wound healed gradually without producing any pus, and the axillary cavity also filled in; the patient nevertheless continued to run an irregular temperature, swinging from 98° to 101° , pulse 100 to 130 per minute. A post-operative cough soon cleared up and no abnormal signs could be detected in the chest. The pain in the loin gradually subsided and the patient appeared comfortable, though flushed and lethargic. After some weeks the fever subsided, and the patient went to a convalescent home. On her return her mother noticed that although she was free of pain she was not her old self. Previously a helpful and willing worker in the home, she now tired

easily and burst into tears on the slightest exertion. She nevertheless attended, and showed every sign of appreciating, the annual Christmas party in the Surgery.

Three weeks later she returned to the Surgery complaining of lack of appetite, drowsiness, flushing, and fainting fits. She did not complain of any pain, and apart from a slight contracture of the axillary scar, nothing abnormal could be discovered except for a temperature of 99.6°.

On January 20th, five days later, she complained of pain at the posterior end of the lumbar scar. On examination there was some deep tenderness, but no oedema or obvious inflammation; leucocytes 9000 per c.mm. Kaolin was applied, and within 36 hours an abscess pointed and burst, releasing about 2 oz. of thick creamy pus. The abscess-cavity was found to extend to a depth of 1½ in. but no farther; the wound slowly filled from the bottom and healed, the discharge almost disappearing.

For the first seven days the patient was completely apyrexial, but the temperature then rose suddenly to 101°, and for the next two weeks oscillated; no abnormality could be found except for a transient sore throat, the child refusing to admit to any pain or discomfort at all, the loin being quite free of tenderness. The leucocyte count was at first only 8800, but on February 12th it rose to 14,800 per c.mm.; the temperature range was 98° to 102°, the pulse about 110 per minute. Examination of the urine revealed a slight trace of albumen, no red blood-cells or crystals, 3 to 4 white blood-cells, and a few mucous casts. Cultures were sterile.

The local signs were: complete absence of pain, tenderness or rigidity in the left loin, but a swelling could be felt on bimanual examination. This swelling corresponded to the lower pole of the kidney, but did not move on respiration. The abscess-cavity had closed to a small, clean granulating area, and there was no sign of sinus formation and no oedema. The patient's general condition was excellent.

Plain X-rays and uroselectan films of the urinary tract were taken and were fortunately very distinct (see Fig. 1); the following points could be made out:

- (a) The left kidney was larger than the right.
- (b) Although the left pelvis was higher than the right, the lower poles were on the same level; there seemed to be a deformity of the inferior and lateral border, the ureter being pushed medially.
- (c) The lower calyx was not well shown, and appeared to form a wide angle with the others.

On these findings a diagnosis of a "carbuncle" involving the lower pole of the left kidney was made. As renal function tests were satisfactory, it was decided to perform nephrectomy (February 24th).

The old scar was first excised and the incision

lengthened. Progress was rendered difficult by dense fibrous tissue from the previous suppuration, but no track could be made out. The kidney was found to be closely adherent to the lumbar muscles and separation proved extremely difficult; in the course of this process the operating finger lacerated the lower pole, which was very friable, and thick yellow pus escaped. In order to facilitate delivery a portion of the twelfth rib was resected. The upper pole seemed to be relatively normal to inspection and palpation. The renal pedicle was extremely short, so that only one clamp could be applied, and the whole pedicle had to be secured with one ligature. The cavity was swabbed out with 50% dettol and drained with corrugated rubber, the tissues being closed round the drains.

After operation the temperature fell to normal in five days, and never rose again. The wound discharged freely for a time, but gradually and progressively closed, till on April 12th the patient was discharged from Hospital, to all appearances in perfect health and as lively as ever.

The affected kidney is normal in size (10 × 6 × 3 cm.); the capsule is absent, the upper third of the outer surface apparently normal, the lower two-thirds bulging downwards and outwards, its surface lacerated and discharging pus. The cut surface shows the lower two-thirds to be replaced by firm white granulation-tissue in which there are numerous small abscess-cavities; the pelvis of the kidney is free of pus and, apart from fatty changes, the remainder of the organ is normal.

Section shows considerable areas of kidney-tissue replaced by granulation-tissue in which there are numerous abscesses. The kidney tissue is widely infiltrated by polymorphonuclear leucocytes, and many of the surviving tubules contain pus.

Direct Gram films show Gram-positive cocci in clumps, and cultures on B.L.A. yield a pure growth of *Staphylococcus pyogenes aureus*.

The study of these two and other recorded examples shows that the condition forms a definite clinical picture, which can be recognized, though its occurrence is somewhat rare. It may occur at any age and in either sex. Characteristically the prelude is some focus of staphylococcal infection, most often in the skin, but, as in No. 1, this may escape notice. This is followed by a period of comparative absence of symptoms, after which the patient develops malaise, pyrexia and pain in the loin with leucocytosis and other signs suggesting perinephric abscess. On exploration no pus is found in the perinephric tissues, or if some is present it is seen to be originating from the kidney. The patient's condition fails to improve until nephrectomy has been carried out.

Although blood-cultures have hitherto proved negative, it appears undoubted that the infection reaches the kidney by the blood-stream, and is the result of a pyæmia which may produce abscesses elsewhere, as in the prostate (No. 1). The lesion is a septic infarct, consisting of a number of confluent multiple abscesses in the renal cortex; hence the term "carbuncle", on which some people frown. It is true that the term is more suitable as a description of the superficial lesion, but it is difficult to suggest an alternative when it is in the kidney. It can be said that there is little harm in using an expression so picturesque in describing a lesion so unusual. The lesion differs from the more usual "pyæmic kidney" in that only one side is affected, and the changes are not diffuse but circumscribed and confined to one part of the kidney, the remainder of the organ being relatively unaffected. As suppuration proceeds, pus may force its way through the renal capsule into the perinephric tissues, thus forming a secondary perinephric abscess; only rarely does it spread to the renal pelvis. In both these patients the urine was free of pus or red cells and sterile on culture.

The diagnosis is made on the history of a staphylococcal infection followed by the development of fever, pain in the loin and leucocytosis. So far it is indistinguishable from perinephric abscess, a closely related and more frequently encountered condition. The presence of acute superficial tenderness and œdema favours the diagnosis of perinephric abscess, since in renal carbuncle the tenderness is deeper; the presence of a palpable swelling in the loin is in favour of the latter, but it may be masked by muscle spasm.

The X-ray appearances are characteristic; while a good plain film may show a deformity of the renal shadow, intravenous pyelography demonstrates the Y-shaped appearance produced by the spreading-out of the calyces by the swelling; this can also be seen in hypernephroma.

The excreting power of the affected kidney does not seem to be appreciably impaired.

Only one method of treatment will cure the condition, and that is nephrectomy. If the patient's clinical condition is unsatisfactory, temporary improvement may be obtained by simple drainage of the kidney, but nephrectomy should be carried out as soon as possible. If this is done the prognosis is good. Both these patients are now in excellent health. Reports of others not treated by nephrectomy indicate a fatal prognosis, drainage alone being of no lasting value.

For permission to publish these notes and for suggestions in writing this article I am greatly indebted to Mr. Geoffrey Keynes, to Mr. W. Girling Ball, and to Mr. William Underwood.

THIS FORTRESS . . .

By J. T. HAYWARD-BUTT, M.R.C.S., L.R.C.P.

"This fortress, built by Nature for itself,
Against infection and the hand of war."
King John, Act ii, Sc. 1.

I HAVE been persuaded to put on record a certain operation that took place at sea. The reasons for this are threefold: First, a certain number of rather misleading press notices; secondly, considerable ribald comment, and lastly, the glorious realization that I shall never have to tell the story again.

I would like to point out beforehand that any unrehearsed touches that may have crept into the "theatre" were entirely due to the conditions prevailing at the time. The ship was fully equipped with standard Board of Trade drugs and instruments, and is inspected before each voyage by one of their officials and by the surgeon.

Leaving Brisbane we were forced to drop anchor at the mouth of the river, as a cyclone raging outside in Morton Bay made navigation impossible. We hove to for twelve hours alongside a small fleet of liners and tankers.

The next morning, visibility being somewhat improved, the Captain decided to run the North-West Channel. He was a man of boundless courage and, I believe, one of the finest navigators afloat. The Pilot was not so happy about it, and later developed diarrhœa.

Incidentally the "Old Man" and I had dined not wisely but too well on two-and-a-half-dozen oysters and a crab each on the previous night, and were both laid up for twelve hours with N.V.D.++ and the most agonizing and horrible pains.

However, we got through the surf, bravely followed by the tramps and others.

That evening a senior steward came to me complaining of a relapse of dysentery. He had had diarrhœa for three days and some pains originating round the umbilicus, which had settled down about a hand's-breadth below the right costal margin, occasionally referred to his back. There was no hyperæsthesia, but some tenderness on deep palpation about 2 in. above McBurnie's point. Ballooning the cæcum gave a sharp pain in this area on release. T. 99°, P. 92, R. 16. No signs of cholecystitis, or renal or chest involvement. The recti were not on guard and P.R. showed no tenderness. He had vomited once.

He had a history of a somewhat similar attack a year before, diagnosed by the ship's surgeon as dysentery and treated with injections.

Following Samuel Johnson's aphorism, although there was "no fiery throbbing pain", I suspected "cold gradations of decay", diagnosed a high retro-cæcal appendicular obstruction and decided to open him.

I might have asked the Captain to put back into Brisbane, but we could never have made that passage by night with the sea which was running, and it would not have amused him to make it again even by daylight. Further, these ships run to schedule like a train, and 500 passengers were waiting in Sydney.

There was no assistant surgeon on board, as we were due to collect him at Sydney. The Sister was a good nurse, but her theatre technique was naturally somewhat rusty.

By ageless tradition at sea, asepsis is considered to be highly commendable but rather impracticable, and the ship is looked upon as a vast, beautifully sterile kidney-bowl.

I reported to the Captain, who gave orders that the ship should, at the appointed time, be hove to, or run at a critical speed into the sea and the wind, to minimize the movement, which was by now considerable. The rolling and pitching were bad enough, but the pounding by far the worst. This occurred each time she lifted her bows high in the air, reeled, and smashed her nose into the oncoming sea, jarring the ship from stem to stern.

Being but lightly loaded as yet (the first day homeward bound), she would sometimes lift her propellers clear of the water, and then, racing madly, they would suddenly bite again with a jerk that shook the ship.

I think my feelings then could be more or less summed up as follows :

"Willing to wound, and yet afraid to strike."

Pope.

"The blood will flow where the knife is driven,
The flesh will quiver where the pincers tear."

Shakespeare.

And, rather pathetically—

"Ah me, we wound where we never intended to strike."

Thackeray.

I had a quite adequate "operation set" in a sealed drum. This, on opening, revealed 2 gowns and caps, 2 pairs rubber gloves, size ? 9 or 10, 8 sterile "face towels", swabs, etc. Instruments consisted of 6 Spencer-Wells, 2 Lane's forceps, 2 Dissecting forceps, 2 scalpels (one for the surgery pencil), needle holder, some 400 needles of all kinds, catgut 0, 1 and 3, and, believe it or not, Morrant-Baker forceps.

The operating theatre was 6 ft. wide by 10 ft. long and at other times was the surgery, and dispensary—consequently a mass of bottles, cupboards, etc. This was fortunate as, failing to lash myself to the bulkhead, I was able to lean firmly against a cupboard to keep my balance, and only fell into the wound twice.

Four stalwart sailors carried the patient on to the table, and I prepared to give him a spinal.

After he had fallen off twice I recalled the stalwarts, who gazed fascinated at the long needle disappearing into his back. When the c.s.f. began to flow I heard

one turn to another and mutter, "Gawd, he's punctured 'is bladder".

I gave 15 c.c. spinal percaïne, which gave an excellent anaesthesia to the costal margin. This, of course, was a large quantity, but, having no anaesthetist, I had to be sure. I also used 2% novocaine as a local.

Morphia gr. $\frac{1}{2}$ and hyoscine gr. $\frac{1}{150}$ were not a success, as the patient began to rave and struck the hospital attendant a low and telling blow. I sent him off the field to recover, which he did, and returned when his substitute, a man like an ox, said he had come all over queer-like, and could he have some brandy.

I had by now made the skin incision, and would have gone on had not the patient wrenched his hand free, dipped a finger in the wound, gazed at it, cried "Ooooh—blood!" and passed out. I now had him lashed down to the table and cleared the theatre.

On opening the abdominal cavity I found a dense mass of adhesions, probably the aftermath of an operation he had had in America for "quitarrhal jaundice". The cæcum was tightly adherent to the posterior abdominal wall, and required a very long and tedious blunt dissection for mobilization. Some coils of small intestine were adherent to everything within reach, and there seemed a perfect lattice-work of fibrous girders to the anterior parietal peritoneum. I did not think it tuberculous.

The patient was still restless and occasionally raved, and sleep was "still last to come where thou art wanted most". The question of further anaesthesia came up. I considered the pros and cons of evipan:

Indications.—Unconsciousness and above all peace and quiet.

Contra-indications.—That it would require frequent repetition. That I could expect little aseptic assistance. That to unwrap the cocoon would be asking for trouble; he would inevitably precipitate like a cloud of albumen on the deck.

Conclusion.—Morphia gr. $\frac{1}{4}$.

Progression was appallingly slow due mainly to the following reasons:

(a) I had personally to supervise the sterilization and lay-out of all instruments. I had to thread my own needles, cut ligatures, etc., as the nurse was somewhat nervous, and, anyway, only one of us could lean on his belly at one time.

(b) The only time one could do any delicate work of any kind was the moment the ship passed the vertical in between the rolls.

(c) The density of the adhesions and the glue-like, obstinate adherence of the cæcum.

(d) The high retrocæcal appendix, which could be felt but not seen.

(e) The delay while the surgeon recovered from periodic attacks of violent intestinal colic, and wondered if it was true what they said about opium.

(f) The stifling heat of a tropical cyclone.

(g) The verbal conflict with the patient, who was awfully grateful for what had been done, but regretted he could wait no longer as the passengers would be coming down for tea.

And (h) last, but not least, the heated discussion between the electricians (who were standing by with emergency lights) as to the chances of getting brandy or castor oil if one of them were to faint.

And then came the aerial attack.

It was over 100° F. in the room, and the moisture had condensed on the cold freezer pipe running fore and aft across the ceiling; thus each time she pitched at all violently, there were "the pitter-patter of the rain-drops" all the way along from his toes to his face, and back again. At first I would chase and catch them in a little sterile bowl, but soon grew tired of this—anyway it looked pretty stupid.

Of gloomy prognosis here, is the Anacreon paraphrase:

"The thirsty wound soaks up the rain,
And drinks and gapes for drink again.
The germs suck in the wound, and are
With constant drinking, fresh and fair."

However, is there not in Rabelais the proverb, "Petite pluie abort grand vent"?

And at least it kept the moist swabs moist.

After the third hour the patient became a pure menace, morphia and/or hyoscine seemed purely to excite him, so I roped in the hospital orderly to give an open ether.

No persuasion or orders on my part could convince him that more than a few drops were necessary. Eventually he got the patient into the excitement stage, but deeper he would not go, in spite of the volume of ether I told him to give. Later I discovered he was pouring it down one side with cotton-wool in his hand and terror in his heart.

Just then the Purser came down and started mumbling about iced lager, so I called him in to give the anæsthetic—which he did pretty well, though his eyes nearly fell out of his head.

By this time I had removed the appendix, which was 6 in. long and kinked through 135° in the middle by a fibrous band running over it. The proximal half was natural, but the distal was darkly engorged and would, without doubt, have gone on very shortly to gangrene. There was one appendicular artery and a meso-appendix scarcely 2 in. long, though the appendix was adherent along its length to the posterior wall of the cæcum.

The Chief Electrician, who had been holding the

patient's legs (the while gazing steadfastly at the floor), thinking I had finished, looked up, saw as he said "a soup-plate of tripe", went light-green and abandoned ship, shortly followed by the Purser, who shot out muttering something about "smell of the ether".

The nurse for the last quarter of an hour had, for the third time, been in a corner hanging her head in shame and her hands in spirit, for falling against a non-sterile bulkhead.

So I finished in splendid isolation, after 4½ hours of this my first appendicectomy!

As a sort of gesture, my hospital steward threw everything overboard afterwards, including gowns, caps, towels, gloves, and finally the appendix, complete with Spencer-Wells.

The following day the patient's temperature rose solemnly but not surprisingly to 103° and the pulse began to climb.

I, like Milton's—

"Earth felt the wound; and Nature from her seat,
Sighing through all her works, gave signs of woe,
That all was lost."

However, he rapidly returned to normal in 24 hours with the exhibition of patience, prayer, and prontosil.

He returned to light duty on the 19th day, and full duty on the 21st day.

I would like to acknowledge my deep gratitude to the White Cells, to whose gallant, selfless mobilization and untiring phagocytic collaboration I feel a vast measure of the success was due.

ART EXHIBITION

Opening Monday, June 13,
for One Week, in the
Great Hall

Being an Exhibition of
Work by the Staff,
Students, Nurses and
Porters associated with
the Hospital

ADMISSION FREE

VIEW DAY

THERE is an atmosphere peculiar to the big social occasion, whatever it may be, whether prize day at school, the local fête, or View Day at Bart.'s. There is a subdued and half-secretive excitement in the morning—clean sheets on the beds, the tinkle of myriad tea-cups in the ward kitchens, and the unwonted sight of rich cakes being carried across the

There is a momentary flurry as the crowd surges to see him pass, and once more the bee-hive atmosphere descends.

Some impatient viewers tire of expectant waiting and wander off to the Museum and out-patient exhibits. The exclamations of amazement, appreciation, of ill-concealed boredom, or of scarcely suppressed excitement are the same in the dispensary at Bart.'s as in the Cucumber Tent at Little Slowcombe, except that in our case some questions may need embarrassed parrying with a deft misstatement.



THE PARTY BEGAN TO GATHER IN EARNEST.

Square. Then there is a preliminary ceremony attended by a select few—in our case the lunch over at Charterhouse for the Treasurer and Almoners and the Staff (enlivened this year by the unexpected presence of a mixed audience, whose appearance startled the Dean and Warden into consultation, but not into action). Soon a crescendo of excitement is felt as the party begins to gather in earnest for the business of the day. The Square takes on an appearance which it wears but once in the year. Housemen in their splendid isolation of sleek tail coat and carnation, outshining for once their chiefs, who strut or stroll about *en famille*. Mothers proud of their student sons, girl friends eyeing one another's finery, nurses in and out of uniform, all standing, talking, looking, waiting; sun shining, fountain playing. For a moment there is a hush as the object of it all appears. The Treasurer, led in procession, crosses on his way from block to block.

In the Square a sudden rush shows that the main block is open, and the whole party ascends to tea in the wards. Hard to believe on View Day, with the sun a-shining, that these amused and contented-looking patients are ill. Some wards have special exhibits, such as a meccano-like extension apparatus, and "Lizzie" is inevitably a centre of attraction with the gay little swinging cots.

Few and fortunate were those who saw Lord Horder's portrait (albeit looking like a King's pawn scornfully refusing to consider moving one square further), presented to him by Lord Stanmore on behalf of the subscribers. The portrait is most welcome. May it adorn the Great Hall for many View Days to come.

Now the last stage sets in. The conversational hum lowers its tone as one by one the visitors retreat. "So kind of you . . ." "So glad you came . . ." "most interesting . . ." and the atmosphere is one



SIR WALTER LANGDON-BROWN WAS PRESENT.

of anti-climax. The scraps are tidied up, the patients washed. The Housemen return their glory to its mossy home, and Bart.'s is once more Bart.'s of every day.

OUR CANDID CAMERA



"I have to hold my hand out here or else I'd topple over backwards."

MUSICIANS, MUSIC AND MEDICINE

By E. C. O. JEWESBURY, M.B., B.S., M.R.C.P.

IT has been said that there are two musical races in the world, the birds and the humans, and that of these the humans are the more musical, since they sing all the year round. Most birds, moreover, are but simple-minded musicians, having nothing but "folk-songs", handed down from father to son, in some cases varied a little with the season, but passing from generation to generation quite unchanged. But Man, having perfected the art of speech, has been stimulated perhaps by a sense of mimicry and of rhythm, and so has produced at first simple tune-scrap and primitive instruments, then choral harmony and musical notation, and so, finally, the complexity of a modern orchestral score; thus he has ultimately made for himself an art of impressive significance. With the development of music has come the development of the musical sense, and the expression in music of all forms of human feeling in addition to mere rhythm.

The earliest known attempt at musical notation is cut on a marble slab and is known as the Delphic Hymn to Apollo, ascribed to the year 278 B.C.; but Music stood still for another twelve hundred years, when it occurred to someone, probably accidentally, to add a second part to the tune, and so in the tenth century a rude attempt at harmony came into existence. At this time musical notes were being written down simply as letters of the alphabet, A to G being used for an octave. Horizontal lines were first employed as mere guides for writing the words of songs so that the intervals of the melody might be seen. From them, however, developed the pitch lines of to-day. At first varying numbers of lines were tried (from 4 to 15), but the 5-line stave proved the most convenient, and by about 1500 it tended to take the place of all others. Bar-lines, the upright lines drawn across the stave at regular intervals, originated as mere guides at *irregular* intervals to keep the voices together.

Appreciation of music varies notoriously amongst different individuals and different races. Who ever heard of an unmusical Russian or Welshman? And though England no longer deserves to be described, as she was once by a German, as "das Land ohne Musik", nevertheless our natural disposition for music is, sadly enough, not remarkable. There are people in this country, however—and it is an interesting comment on the effect of music—who are quite unable to discriminate between one kind of music and another, and yet who find in orchestral music an agreeable influence, and go to concerts in order to work out some train of thought.

The musical faculty is a curious problem. One may

ask how it is that what profoundly moves one person may not have the slightest effect on another, and, similarly, how of two individuals the one may have a natural sense of pitch, whereas the other may deserve to bear the schoolboy's mistranslation of "Cave Canem"—"Look out, I may sing!" How is it, too, that some people who cannot read a note of music are able to sit down at a piano and play melodies by ear and transpose them without difficulty? Such performers as these usually show a power to extemporize upon given tunes and have marked sensitiveness to harmony. In addition, it is a curious fact that they nearly always show preference for the keys that contain the largest numbers of black notes.

Clearly, the power to play music in this way must be an inherent gift, and one not to be attained by anybody unmusical by nature. No two people are likely to be able to learn music with exactly the same facility. The Mozarts and the Menuhins of the world have some genius or "knack"—a special endowment apart from training—in musical accomplishment, which ordinary musicians can never achieve, no matter how keen their industry or their intellect. Is this endowment necessarily accompanied by other gifts of mind, or may a great musician's comprehension be confined to his music? Are musical ability and musical appreciation necessarily accompanied by an intelligent if not an educated mind? Such questions naturally occur to one and are difficult to answer. That a brilliant mind may be a completely unmusical mind is well known. That simple people may have a great love of music seems also to be true. Musical genius, however, seems to demand powers of memory and mind which exceed those required for the other arts.

One cannot conceive of an unmusical person being made musical, but there are many in whom a latent musical interest has been aroused. Dr. Agnes Savill has related how in her youth she was actively antagonistic to music, and how, when she was taken to a Paderewski concert, she shocked her companion by reading an anatomy cram-book throughout. One day she heard the Chopin preludes played, and, later, although orchestral music had previously made no appeal to her, she was struck by Tchaikovsky's Pathetic Symphony. By developing her interest and taste she was so impressed by the acquisition of a musical appreciation that she wrote a book on her "conversion".

Genius in music has shown itself in remarkable ways. Handel, despite his musical interest being at first severely checked by his surgeon father, was nevertheless before the age of ten an expert on harpsichord, oboe and organ, as well as having written a number of compositions. Mozart, who on the other hand was rigidly trained in music by his father, was at the age of ten able to play at sight almost anything then written for clavier

or violin, and was composing for chorus and orchestra, his first symphony having been written at the age of eight. Beethoven first appeared in a concert aged seven years and three months (understated on the programme as six years), and at the age of twelve was left in charge as official Deputy Court Organist. Weber's first opera, written at the age of twelve, bore the somewhat surprising title "The Power of Love and Wine", while Mendelssohn, before he was fifteen, had written thirteen symphonies, mostly, however, only for strings. When Liszt performed on the piano in public in Vienna at the age of eleven he was approached by Beethoven who greeted him with a kiss—a touching compliment, but perhaps a generous one, since Beethoven was by then practically stone deaf.

Instances of precocity such as these could easily be multiplied, but it is interesting to ponder on the mentality and the ultimate lives of such men. It is commonly believed that musical geniuses are frequently diseased and die young. Thus J. F. Nisbet in *The Insanity of Genius*, wrote: "The biographies of all the greatest musicians are a miserable chronicle of the ravages of nerve-disorder." This, however, is demonstratively untrue. Be it granted that Mozart died at 35, Schubert at 31, Chopin and Weber each at 39, but the first two died of typhus fever and the second two of pulmonary tuberculosis, both diseases being a cause of heavy mortality at a time when knowledge of medicine and sanitation was against a long life.

On the other hand, Verdi lived to be 88, Haydn 77, Liszt 75, Gounod 75, Handel 74 and Wagner 70. In fact, of a number of representative composers chosen from a list which has nothing to do with duration of life and has a range of 400 years, Mr. William Wallace has pointed out that only 23% died under the age of 50, and that the average age of all the composers at death is 61. Many of them, men of genius, died at work.

The family history of musical geniuses has often been inquired into, but in nearly half of them there is no record of any special musical tendencies. The Bachs, of course, form a notable exception, for their musical activity is traceable through eight generations. In the eighteenth century more than 30 of them were musicians of eminence, the greatest being John Sebastian Bach of the sixth generation. He himself had twenty children—"a perpetual parent" they called him—but of these only nine survived him. The last of the Bach line was W. F. E. Bach, who was a London piano teacher for some years and died a very old man in 1845. Musicianship occurred in four generations of Purcells, three of Beethovens, two of Mozarts and four of Webers; but instances like this tend to show merely that the family musicians lived in an atmosphere which naturally

influenced the musical tendencies of their minds (just as the profession of Medicine so frequently runs in families); but that is not heredity. Nor is there any evidence of abundant creative talent persisting in any family outside the Bachs.

The influence which music can exert upon the mentality of both men and animals has been shown in many remarkable ways. Its healing effect has often been stressed, and according to papyri supposed to date from 1500 B.C., the Egyptians employed it in the form of incantations for a variety of ailments. The ancient Greeks and Indians used incantations, as do the medicine-men of a certain native tribe to-day. Specific forms of music have even been recommended for particular conditions. Thus Theophrastus advocated flute-playing in the treatment of sciatica, especially when played in the Phrygian mode (which is animated and spirited). Democritus also commended the analgesic effect of flute music, though he preferred it to be soft. David understood the same type of symptomatic therapy when he employed his harp with such success in the case of Saul.

Several early writers have referred to the value of music in the treatment of bites and stings, and it appeared to have a profound influence upon patients suffering from the "dancing mania", a form of mass hysteria which spread widely throughout Europe from Germany after the horrors of the Plague in the fourteenth century. Entire communities of people would join hands, dance, leap, scream and shake for hours, until they dropped exhausted. Lively shrill tunes played on trumpets and fifes excited the dancers into frenzy, while soft, calm melodies exerted a soothing effect. The condition known as tarantulum which occurred in Italy in the fifteenth century was probably a similar hysterical condition, although it was believed to result after the bite of the tarantula spider. The irritation and terror produced by the bite appeared to be controlled by music, the type of which varied according to the patient. Clarinets and drums were frequently used, though discordant notes seemed to aggravate the malady and therefore had at all costs to be avoided.

Even to-day this form of mob hysteria does not appear to be extinct; witness the following extracts from a London newspaper of recent date:

"Bedlam broke loose in the cinema as soon as the swing orchestra conducted by Benny Goodman started playing.

"Swept by the music into hysteria, people danced in the cinema's aisles and some even leapt on the stage, dancing the Big Apple and screaming loudly.

"Get hot" yelled a young girl, leaping from her seat and flinging herself into a wild execution of the Big Apple. "Swing it," "Feed it out" screamed others.

"Standing in the aisle with a notebook, the noted psychologist, Dr. George Vetter, of New York University, commented:

"I've seen food riots and strikes, but I've never seen the mob mind working so beautifully. Note how they're all wailing in unison. Their screams are like the noise of excited goats.

"Most of the audience are young, and are maturing sexually with no outlet for their emotional urges. Music and the darkened theatre have broken down their inhibitory checks."

"A cinema official said, 'I think they're just plain nuts!'"

Perhaps the Pied Piper of Hamelin knew something about these sorts of conditions.

The animal kingdom is not exempt and snakes are notoriously susceptible, approaching towards the music and swaying in its charm. Lizards are said to show pleasure in music, but wolves and jackals snarl, and dogs, as is well known, often whine lugubriously. Dr. Talmey, who published in an American journal in 1921 some observations on the effects of music on animals, states that cows listening to music tend to produce more milk. Thus is song in the dairymaid abundantly justified!

Since it is unlikely that animals can respond to music from the same emotional causes as mankind, it would appear that the effect is upon the autonomic nervous system and the involuntary muscles. Somatic effects of psychological origin are familiar to everyone, whether they be the alimentary disturbances of anxiety, the tachycardia of undue excitement or the "sinking feeling" of sudden despair. There are many who, during a concert, experience the sensation of cold water slowly trickling down the back, and other more measurable changes are known to occur. Thus, an increase of pulse-rate, a rise of blood-pressure and altered respiratory rhythm have all been observed in people listening to music, and these changes are most marked in those whose musical appreciation is the keenest.

In certain instances music may produce undesirable effects. Thus in the condition described by Macdonald Critchley as musicolepsia, epileptic attacks, both of minor and major varieties, may be produced by some reflex mechanism as a result of listening to music. In a number of instances he has been able to produce classical major epileptic attacks in such people by playing suitable gramophone records. The type of music that is effective varies in different cases, as does the patient's musical knowledge and appreciation.

There is at present attending the Neurological Clinic of St. Bartholomew's Hospital a patient, æt. 31, who since the age of sixteen has suffered from epileptic attacks about once a month, and these attacks are almost invariably brought on by hearing organ music on the wireless, in church or in a cinema. Barrel organs and gramophones sometimes induce attacks. When he is upset by music, his pulse, blood-pressure and respiration show the changes that have been mentioned and he is overcome by nausea and discomfort, which may pass off, or which may go on to a major fit, in which he bites his tongue and is incontinent. There appears to be no hysterical basis whatever to these attacks.

I might have asked the Captain to put back into Brisbane, but we could never have made that passage by night with the sea which was running, and it would not have amused him to make it again even by daylight. Further, these ships run to schedule like a train, and 500 passengers were waiting in Sydney.

There was no assistant surgeon on board, as we were due to collect him at Sydney. The Sister was a good nurse, but her theatre technique was naturally somewhat rusty.

By ageless tradition at sea, asepsis is considered to be highly commendable but rather impracticable, and the ship is looked upon as a vast, beautifully sterile kidney-bowl.

I reported to the Captain, who gave orders that the ship should, at the appointed time, be hove to, or run at a critical speed into the sea and the wind, to minimize the movement, which was by now considerable. The rolling and pitching were bad enough, but the pounding by far the worst. This occurred each time she lifted her bows high in the air, reeled, and smashed her nose into the oncoming sea, jarring the ship from stem to stern.

Being but lightly loaded as yet (the first day homeward bound), she would sometimes lift her propellers clear of the water, and then, racing madly, they would suddenly bite again with a jerk that shook the ship.

I think my feelings then could be more or less summed up as follows :

"Willing to wound, and yet afraid to strike."

Pope.

"The blood will flow where the knife is driven,
The flesh will quiver where the pincers tear."

Shakespeare.

And, rather pathetically—

"Ah me, we wound where we never intended to strike."

Thackeray.

I had a quite adequate "operation set" in a sealed drum. This, on opening, revealed 2 gowns and caps, 2 pairs rubber gloves, size ? 9 or 10, 8 sterile "face towels", swabs, etc. Instruments consisted of 6 Spencer-Wells, 2 Lane's forceps, 2 Dissecting forceps, 2 scalpels (one for the surgery pencil), needle holder, some 400 needles of all kinds, catgut 0, 1 and 3, and, believe it or not, Morrant-Baker forceps.

The operating theatre was 6 ft. wide by 10 ft. long and at other times was the surgery, and dispensary—consequently a mass of bottles, cupboards, etc. This was fortunate as, failing to lash myself to the bulkhead, I was able to lean firmly against a cupboard to keep my balance, and only fell into the wound twice.

Four stalwart sailors carried the patient on to the table, and I prepared to give him a spinal.

After he had fallen off twice I recalled the stalwarts, who gazed fascinated at the long needle disappearing into his back. When the c.s.f. began to flow I heard

one turn to another and mutter, "Gawd, he's punctured 'is bladder".

I gave 15 c.c. spinal percaine, which gave an excellent anæsthesia to the costal margin. This, of course, was a large quantity, but, having no anæsthetist, I had to be sure. I also used 2% novocaine as a local.

Morphia gr. $\frac{1}{2}$ and hyoscine gr. $\frac{1}{150}$ were not a success, as the patient began to rave and struck the hospital attendant a low and telling blow. I sent him off the field to recover, which he did, and returned when his substitute, a man like an ox, said he had come all over queer-like, and could he have some brandy.

I had by now made the skin incision, and would have gone on had not the patient wrenched his hand free, dipped a finger in the wound, gazed at it, cried "Ooooh—blood!" and passed out. I now had him lashed down to the table and cleared the theatre.

On opening the abdominal cavity I found a dense mass of adhesions, probably the aftermath of an operation he had had in America for "quitarrrhal jaundice". The cæcum was tightly adherent to the posterior abdominal wall, and required a very long and tedious blunt dissection for mobilization. Some coils of small intestine were adherent to everything within reach, and there seemed a perfect lattice-work of fibrous girders to the anterior parietal peritoneum. I did not think it tuberculous.

The patient was still restless and occasionally raved, and sleep was "still last to come where thou art wanted most". The question of further anæsthesia came up. I considered the pros and cons of evipan:

Indications.—Unconsciousness and above all peace and quiet.

Contra-indications.—That it would require frequent repetition. That I could expect little aseptic assistance. That to unwrap the cocoon would be asking for trouble; he would inevitably precipitate like a cloud of albumen on the deck.

Conclusion.—Morphia gr. $\frac{1}{4}$.

Progression was appallingly slow due mainly to the following reasons:

(a) I had personally to supervise the sterilization and lay-out of all instruments. I had to thread my own needles, cut ligatures, etc., as the nurse was somewhat nervous, and, anyway, only one of us could lean on his belly at one time.

(b) The only time one could do any delicate work of any kind was the moment the ship passed the vertical in between the rolls.

(c) The density of the adhesions and the glue-like, obstinate adherence of the cæcum.

(d) The high retrocæcal appendix, which could be felt but not seen.

(e) The delay while the surgeon recovered from periodic attacks of violent intestinal colic, and wondered if it was true what they said about opium.

(f) The stifling heat of a tropical cyclone.

(g) The verbal conflict with the patient, who was awfully grateful for what had been done, but regretted he could wait no longer as the passengers would be coming down for tea.

And (h) last, but not least, the heated discussion between the electricians (who were standing by with emergency lights) as to the chances of getting brandy or castor oil if one of them were to faint.

And then came the aerial attack.

It was over 100° F. in the room, and the moisture had condensed on the cold freezer pipe running fore and aft across the ceiling; thus each time she pitched at all violently, there were "the pitter-patter of the rain-drops" all the way along from his toes to his face, and back again. At first I would chase and catch them in a little sterile bowl, but soon grew tired of this—anyway it looked pretty stupid.

Of gloomy prognosis here, is the Anacreon paraphrase:

"The thirsty wound soaks up the rain,
And drinks and gapes for drink again.
The germs suck in the wound, and are
With constant drinking, fresh and fair."

However, is there not in Rabelais the proverb, "Petite pluie abort grand vent"?

And at least it kept the moist swabs moist.

After the third hour the patient became a pure menace, morphia and/or hyoscine seemed purely to excite him, so I roped in the hospital orderly to give an open ether.

No persuasion or orders on my part could convince him that more than a few drops were necessary. Eventually he got the patient into the excitement stage, but deeper he would not go, in spite of the volume of ether I told him to give. Later I discovered he was pouring it down one side with cotton-wool in his hand and terror in his heart.

Just then the Purser came down and started mumbling about iced lager, so I called him in to give the anæsthetic—which he did pretty well, though his eyes nearly fell out of his head.

By this time I had removed the appendix, which was 6 in. long and kinked through 135° in the middle by a fibrous band running over it. The proximal half was natural, but the distal was darkly engorged and would, without doubt, have gone on very shortly to gangrene. There was one appendicular artery and a meso-appendix scarcely 2 in. long, though the appendix was adherent along its length to the posterior wall of the cæcum.

The Chief Electrician, who had been holding the

patient's legs (the while gazing steadfastly at the floor), thinking I had finished, looked up, saw as he said "a soup-plate of tripe", went light-green and abandoned ship, shortly followed by the Purser, who shot out muttering something about "smell of the ether".

The nurse for the last quarter of an hour had, for the third time, been in a corner hanging her head in shame and her hands in spirit, for falling against a non-sterile bulkhead.

So I finished in splendid isolation, after 4½ hours of this my first appendicectomy!

As a sort of gesture, my hospital steward threw everything overboard afterwards, including gowns, caps, towels, gloves, and finally the appendix, complete with Spencer-Wells.

The following day the patient's temperature rose solemnly but not surprisingly to 103° and the pulse began to climb.

I, like Milton's—

"Earth felt the wound; and Nature from her seat,
Sighing through all her works, gave signs of woe,
That all was lost."

However, he rapidly returned to normal in 24 hours with the exhibition of patience, prayer, and prontosil.

He returned to light duty on the 19th day, and full duty on the 21st day.

I would like to acknowledge my deep gratitude to the White Cells, to whose gallant, selfless mobilization and untiring phagocytic collaboration I feel a vast measure of the success was due.

ART EXHIBITION

Opening Monday, June 13,
for One Week, in the
Great Hall

Being an Exhibition of
Work by the Staff,
Students, Nurses and
Porters associated with
the Hospital

ADMISSION FREE

VIEW DAY

THERE is an atmosphere peculiar to the big social occasion, whatever it may be, whether prize day at school, the local fête, or View Day at Bart.'s. There is a subdued and half-secretive excitement in the morning—clean sheets on the beds, the tinkle of myriad tea-cups in the ward kitchens, and the unwonted sight of rich cakes being carried across the

There is a momentary flurry as the crowd surges to see him pass, and once more the bee-hive atmosphere descends.

Some impatient viewers tire of expectant waiting and wander off to the Museum and out-patient exhibits. The exclamations of amazement, appreciation, of ill-concealed boredom, or of scarcely suppressed excitement are the same in the dispensary at Bart.'s as in the Cucumber Tent at Little Slowcombe, except that in our case some questions may need embarrassed parrying with a deft misstatement.



THE PARTY BEGAN TO GATHER IN EARNEST.

Square. Then there is a preliminary ceremony attended by a select few—in our case the lunch over at Charterhouse for the Treasurer and Almoners and the Staff (enlivened this year by the unexpected presence of a mixed audience, whose appearance startled the Dean and Warden into consultation, but not into action). Soon a crescendo of excitement is felt as the party begins to gather in earnest for the business of the day. The Square takes on an appearance which it wears but once in the year. Housemen in their splendid isolation of sleek tail coat and carnation, outshining for once their chiefs, who strut or stroll about *en famille*. Mothers proud of their student sons, girl friends eyeing one another's finery, nurses in and out of uniform, all standing, talking, looking, waiting; sun shining, fountain playing. For a moment there is a hush as the object of it all appears. The Treasurer, led in procession, crosses on his way from block to block.

In the Square a sudden rush shows that the main block is open, and the whole party ascends to tea in the wards. Hard to believe on View Day, with the sun a-shining, that these amused and contented-looking patients are ill. Some wards have special exhibits, such as a meccano-like extension apparatus, and "Lizzie" is inevitably a centre of attraction with the gay little swinging cots.

Few and fortunate were those who saw Lord Horder's portrait (albeit looking like a King's pawn scornfully refusing to consider moving one square further), presented to him by Lord Stanmore on behalf of the subscribers. The portrait is most welcome. May it adorn the Great Hall for many View Days to come.

Now the last stage sets in. The conversational hum lowers its tone as one by one the visitors retreat. "So kind of you . . ." "So glad you came . . ." "most interesting . . ." and the atmosphere is one



SIR WALTER LANGDON-BROWN WAS PRESENT.

of anti-climax. The scraps are tidied up, the patients washed. The Housemen return their glory to its mossy home, and Bart.'s is once more Bart.'s of every day.

OUR CANDID CAMERA



"I have to hold my hand out here or else I'd topple over backwards."

MUSICIANS, MUSIC AND MEDICINE

By E. C. O. JEWESBURY, M.B., B.S., M.R.C.P.

IT has been said that there are two musical races in the world, the birds and the humans, and that of these the humans are the more musical, since they sing all the year round. Most birds, moreover, are but simple-minded musicians, having nothing but "folk-songs", handed down from father to son, in some cases varied a little with the season, but passing from generation to generation quite unchanged. But Man, having perfected the art of speech, has been stimulated perhaps by a sense of mimicry and of rhythm, and so has produced at first simple tune-scrap and primitive instruments, then choral harmony and musical notation, and so, finally, the complexity of a modern orchestral score; thus he has ultimately made for himself an art of impressive significance. With the development of music has come the development of the musical sense, and the expression in music of all forms of human feeling in addition to mere rhythm.

The earliest known attempt at musical notation is cut on a marble slab and is known as the Delphic Hymn to Apollo, ascribed to the year 278 B.C.; but Music stood still for another twelve hundred years, when it occurred to someone, probably accidentally, to add a second part to the tune, and so in the tenth century a rude attempt at harmony came into existence. At this time musical notes were being written down simply as letters of the alphabet, A to G being used for an octave. Horizontal lines were first employed as mere guides for writing the words of songs so that the intervals of the melody might be seen. From them, however, developed the pitch lines of to-day. At first varying numbers of lines were tried (from 4 to 15), but the 5-line stave proved the most convenient, and by about 1500 it tended to take the place of all others. Bar-lines, the upright lines drawn across the stave at regular intervals, originated as mere guides at *irregular* intervals to keep the voices together.

Appreciation of music varies notoriously amongst different individuals and different races. Who ever heard of an unmusical Russian or Welshman? And though England no longer deserves to be described, as she was once by a German, as "das Land ohne Musik", nevertheless our natural disposition for music is, sadly enough, not remarkable. There are people in this country, however—and it is an interesting comment on the effect of music—who are quite unable to discriminate between one kind of music and another, and yet who find in orchestral music an agreeable influence, and go to concerts in order to work out some train of thought.

The musical faculty is a curious problem. One may

ask how it is that what profoundly moves one person may not have the slightest effect on another, and, similarly, how of two individuals the one may have a natural sense of pitch, whereas the other may deserve to bear the schoolboy's mistranslation of "Cave Canem"—"Look out, I may sing!" How is it, too, that some people who cannot read a note of music are able to sit down at a piano and play melodies by ear and transpose them without difficulty? Such performers as these usually show a power to extemporize upon given tunes and have marked sensitiveness to harmony. In addition, it is a curious fact that they nearly always show preference for the keys that contain the largest numbers of black notes.

Clearly, the power to play music in this way must be an inherent gift, and one not to be attained by anybody unmusical by nature. No two people are likely to be able to learn music with exactly the same facility. The Mozarts and the Menuhins of the world have some genius or "knack"—a special endowment apart from training—in musical accomplishment, which ordinary musicians can never achieve, no matter how keen their industry or their intellect. Is this endowment necessarily accompanied by other gifts of mind, or may a great musician's comprehension be confined to his music? Are musical ability and musical appreciation necessarily accompanied by an intelligent if not an educated mind? Such questions naturally occur to one and are difficult to answer. That a brilliant mind may be a completely unmusical mind is well known. That simple people may have a great love of music seems also to be true. Musical genius, however, seems to demand powers of memory and mind which exceed those required for the other arts.

One cannot conceive of an unmusical person being made musical, but there are many in whom a latent musical interest has been aroused. Dr. Agnes Savill has related how in her youth she was actively antagonistic to music, and how, when she was taken to a Paderewski concert, she shocked her companion by reading an anatomy cram-book throughout. One day she heard the Chopin preludes played, and, later, although orchestral music had previously made no appeal to her, she was struck by Tchaikovsky's Pathetic Symphony. By developing her interest and taste she was so impressed by the acquisition of a musical appreciation that she wrote a book on her "conversion".

Genius in music has shown itself in remarkable ways. Handel, despite his musical interest being at first severely checked by his surgeon father, was nevertheless before the age of ten an expert on harpsichord, oboe and organ, as well as having written a number of compositions. Mozart, who on the other hand was rigidly trained in music by his father, was at the age of ten able to play at sight almost anything then written for clavier

or violin, and was composing for chorus and orchestra, his first symphony having been written at the age of eight. Beethoven first appeared in a concert aged seven years and three months (understated on the programme as six years), and at the age of twelve was left in charge as official Deputy Court Organist. Weber's first opera, written at the age of twelve, bore the somewhat surprising title "The Power of Love and Wine", while Mendelssohn, before he was fifteen, had written thirteen symphonies, mostly, however, only for strings. When Liszt performed on the piano in public in Vienna at the age of eleven he was approached by Beethoven who greeted him with a kiss—a touching compliment, but perhaps a generous one, since Beethoven was by then practically stone deaf.

Instances of precocity such as these could easily be multiplied, but it is interesting to ponder on the mentality and the ultimate lives of such men. It is commonly believed that musical geniuses are frequently diseased and die young. Thus J. F. Nisbet in *The Insanity of Genius*, wrote: "The biographies of all the greatest musicians are a miserable chronicle of the ravages of nerve-disorder." This, however, is demonstratively untrue. Be it granted that Mozart died at 35, Schubert at 31, Chopin and Weber each at 39, but the first two died of typhus fever and the second two of pulmonary tuberculosis, both diseases being a cause of heavy mortality at a time when knowledge of medicine and sanitation was against a long life.

On the other hand, Verdi lived to be 88, Haydn 77, Liszt 75, Gounod 75, Handel 74 and Wagner 70. In fact, of a number of representative composers chosen from a list which has nothing to do with duration of life and has a range of 400 years, Mr. William Wallace has pointed out that only 23% died under the age of 50, and that the average age of all the composers at death is 61. Many of them, men of genius, died at work.

The family history of musical geniuses has often been inquired into, but in nearly half of them there is no record of any special musical tendencies. The Bachs, of course, form a notable exception, for their musical activity is traceable through eight generations. In the eighteenth century more than 30 of them were musicians of eminence, the greatest being John Sebastian Bach of the sixth generation. He himself had twenty children—"a perpetual parent" they called him—but of these only nine survived him. The last of the Bach line was W. F. E. Bach, who was a London piano teacher for some years and died a very old man in 1845. Musicianship occurred in four generations of Purcells, three of Beethovens, two of Mozarts and four of Webers; but instances like this tend to show merely that the family musicians lived in an atmosphere which naturally

influenced the musical tendencies of their minds (just as the profession of Medicine so frequently runs in families); but that is not heredity. Nor is there any evidence of abundant creative talent persisting in any family outside the Bachs.

The influence which music can exert upon the mentality of both men and animals has been shown in many remarkable ways. Its healing effect has often been stressed, and according to papyri supposed to date from 1500 B.C., the Egyptians employed it in the form of incantations for a variety of ailments. The ancient Greeks and Indians used incantations, as do the medicine-men of a certain native tribe to-day. Specific forms of music have even been recommended for particular conditions. Thus Theophrastus advocated flute-playing in the treatment of sciatica, especially when played in the Phrygian mode (which is animated and spirited). Democritus also commended the analgesic effect of flute music, though he preferred it to be soft. David understood the same type of symptomatic therapy when he employed his harp with such success in the case of Saul.

Several early writers have referred to the value of music in the treatment of bites and stings, and it appeared to have a profound influence upon patients suffering from the "dancing mania", a form of mass hysteria which spread widely throughout Europe from Germany after the horrors of the Plague in the fourteenth century. Entire communities of people would join hands, dance, leap, scream and shake for hours, until they dropped exhausted. Lively shrill tunes played on trumpets and fifes excited the dancers into frenzy, while soft, calm melodies exerted a soothing effect. The condition known as tarantulism which occurred in Italy in the fifteenth century was probably a similar hysterical condition, although it was believed to result after the bite of the tarantula spider. The irritation and terror produced by the bite appeared to be controlled by music, the type of which varied according to the patient. Clarinets and drums were frequently used, though discordant notes seemed to aggravate the malady and therefore had at all costs to be avoided.

Even to-day this form of mob hysteria does not appear to be extinct; witness the following extracts from a London newspaper of recent date:

"Bedlam broke loose in the cinema as soon as the swing orchestra conducted by Benny Goodman started playing.

"Swept by the music into hysteria, people danced in the cinema's aisles and some even leapt on the stage, dancing the Big Apple and screaming loudly.

"Get hot" yelled a young girl, leaping from her seat and flinging herself into a wild execution of the Big Apple. "Swing it," "Feed it out" screamed others.

"Standing in the aisle with a notebook, the noted psychologist, Dr. George Vetter, of New York University, commented:

"I've seen food riots and strikes, but I've never seen the mob mind working so beautifully. Note how they're all writhing in unison. Their screams are like the noise of excited goats.

"Most of the audience are young, and are maturing sexually with no outlet for their emotional urges. Music and the darkened theatre have broken down their inhibitory checks."

"A cinema official said, 'I think they're just plain nuts!'"

Perhaps the Pied Piper of Hamelin knew something about these sorts of conditions.

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On the other side of the picture, Dr. J. M. T. Duggan has recently described a boy of ten, restless and mischievous to a degree, but whose behaviour in hospital could always be controlled by the wireless or gramophone, to which he would stand listening for hours.

One of the most important and most primitive influences of music is rhythm. A child will try to dance to music, and even the most unmusical people will tap their feet in response to rhythmical airs. The soldier who marches to the band and the sailor who sings his shanties have both discovered for themselves the diminution of fatigue that such music can produce. A regular rhythmical sound is usually pleasing to the ear, whether it be pure music or whether it be the ticking of a clock, the distant hum of a moving machine or the bustle of a railway engine. But irregular rhythm can produce a most disturbing effect, and all of us are aware of the irritation produced by an irregular hammering noise, a window that rattles or a public speaker with a stammer.

The soothing effect of music on the mind has been made use of both as an aid to surgery and in speeding convalescence. The old tooth-drawers who used to travel round the fairs usually had a small brass band outside their tent, allegedly as a means of overcoming pain, but more probably as a method of making any evidence of pain inaudible to would-be clients. Recently, however, and particularly in America, gramophone music has been employed in conjunction with local anaesthesia in the operating theatre. McGlinn states that he has found that the atmosphere of tension is relieved for the patient, and that the sounds of instruments and the like are not so clearly heard by him. Jazz and sentimental music are said to be best avoided, and Dr. J. D. Lee has found that patients prefer string quartets under these conditions.

As to convalescence, in the words of Dr. Drapes, an Irish physician of the last century: "Nothing cheers patients like music, removes depression, assuages grief, quiets excitement; rarely, if ever, does it produce the slightest ill-effect."

Music touches Medicine at many points. Indeed, had not Leopold Auenbrugger been something of an amateur musician, the whole art and meaning of percussion of the chest might have lain undiscovered for many more years. A sense of pitch is a noticeable asset to those who practise percussion. Enough has been said to suggest that perhaps every good physician is a bit of a musician, and every good musician very often a bit of a physician.

PASSIVE PÆDIATRICS

By CHARLES HARRIS, M.D., F.R.C.P.

IN what follows I have set down as precisely as I can the things I remember from the time when at the age of three I spent six weeks as an in-patient in a general hospital in London. The experience is not particularly unusual. Many others could give similar accounts. Yet medical folk have a healthy curiosity about what patients think of hospitals. Children, at this time, are too self-contained to offer grown-ups an opinion of what they think of them and their institutions.

The incidents I recall are isolated, and I am not sure that I can arrange them in their proper order. The episodes which remain in my mind are not static like snapshots; they contain movement over a short period of time like fragments of a cinematograph film and they are, to me, very vivid. To the best of my belief the things I remember did occur. They have not been imagined later nor have they been touched up in the light of experience. In a way I once checked my memory. After my first visit I had no occasion to go to that hospital again for thirty-two years; when I did return there was no difficulty in recognizing the special smell of the hospital, or the passage into the ward in which I stayed.

The first episode in the series was when I learned that I was to go to hospital to have an operation. I was in the kitchen and I overheard my mother telling our servant about it. More from the tone of her voice than from her words I gathered that the prospect was unpleasant, and I disclosed myself as an eavesdropper by a loud outburst of weeping. Most of the journey to hospital is forgotten. There remains, however, a very clear impression of the last part of it on the underground. The carriage was almost incredibly smoky, for all the trains were still drawn by steam engines. I was delighted with the smell and the dirt. The actual approach to the door of the hospital was by an immense flight of steps. I have found out since that there are only six steps; at that time the uppermost was well above the level of my eyes, so it is reasonable still to think of the entrance as something like that of the west front of St. Paul's.

We waited in a bare, dimly-lighted room furnished with wooden benches. Its smell was ominous, but still more menacing was the impersonal, not to say abrupt, way in which those who came and went treated my mother. Later we were in a ward. I was being led away by a nurse. I was in fact rather intrigued by my new surroundings and I might perhaps have left my mother without tears. Suddenly I realized how

very distressed she was. This set me off and there was a considerable scene.

The ward was a women's ward with beds arranged along two sides; the centre was taken up by a desk, two fireplaces with tiled sides and two cots, one of which I came to occupy. From my position I had a view of more than half the beds and, slightly obstructed by the stovepipe of the fire, of the door into the ward. The desk and the green-shaded gas-light which remained alight all night were behind my head.

It would be inaccurate to say that any individual memory of the adult patients remains. Collectively they behaved in what seemed a very un-adult way. They cried and even screamed; they were often afraid; one died very publicly. Sometimes they said remarkable things which, when I repeated them later, led to great embarrassment of grown-ups. Recollection of the occupant of the other cot is by contrast quite clear. Her left hip was in plaster. In the evenings she was put on the floor beside my cot and we had long conversations. She must have been an entertaining person, for these evening sessions stand out with visiting days as the only exceptions to a long period of tedium and discomfort.

To be put into an unusual garment heralded the approach of an operation. Even on the first occasion I was quite clear about this. A porter came to take me to the theatre while I was seeking reassurance from a nurse. In the theatre there were two men in ordinary clothes and what seemed many people in white robes. The two in everyday clothes told me that if I lay down and breathed away quietly I could presently sit up. They applied to my face a rubber mask attached to a long flexible tube. I carried out their instructions and for a while nothing happened. Eventually one said to the other "You'll never do any dam' good like that" and the mask was removed. My part of the bargain complete I prepared to sit up; I have still a feeling of having suffered injustice that I was not allowed to. At the time I was furious with them, for they not only did not let me sit up as they said they would, but very forcibly made me breathe through a foul-smelling rag. The unfairness of the next incident did not therefore come as any surprise to me. It was night again and I was back in the ward. A man came to my cot and later another. The first gave me a penny and the assurance that he would not hurt me. Thereupon with some piece of apparatus he received from a nurse he proceeded to hurt me a great deal. I do not know whether at the time I objected more to the pain or to the insult to my intelligence.

Sundays for some reason seem to have made more impression than other days. Once on a foggy Sunday

afternoon visitors were pouring into the ward. From my cot I watched the door for my parents but they did not come. As time passed and still they did not appear I got into a panic. There was a nurse with a kindly insight who made me understand that she knew what my anxiety was about, and who went out into the front hall apparently to look for my people. I suppose now that there was nothing she could do about it. I know at the time that I attributed their tardy appearance—they had been fogbound—to her activities. Even if she could not get them she at least made me feel something was being done and I am still thankful for her help. On another Sunday it was breakfast-time and the sun shone. I tried the experiment of putting a lump of sugar into the yolk of my soft-boiled egg. The resulting taste was so revolting that I think that the egg must have been bad to begin with. There was quite a row about the mess I made with it. I took it all as a matter of course. I was by then at home in the ward, probably having had a longer stay than anyone else. I knew just about how far I could go with the authorities, and anyway nothing painful was liable to happen on Sundays at breakfast-time.

Leaving hospital and the journey home have left no impression except riding in a cab from the station to our house. The jubilation on the first evening at home is well remembered, as is the fact that it was interrupted by reproof for using obscene language. Parts of my new vocabulary were evidently not for general use. Great was the disappointment I felt at this lack of appreciation of the only fruits of my expedition into a hostile and unpleasant adult world.

WARD ENIGMAS.

Anyone want to buy a screen?
When you know just what they mean
You're in the auction bidding keen.

Anybody, anything for the book?
When you understand the look
Quite unembarrassed heads are shook.

How many frequencies to-day?
Mysterious abstruse way to say
What polite folks never may.

In Dalziel, riddles soon are plain.
What's understood is always gain;
The answers never are in vain.

G. F. H.

A CASE OF DESMOID TUMOUR

By D. R. SYRED.

ON December 9th, 1937, a patient, aged 24, was admitted to Paget Ward under the care of Mr. John Hosford, complaining of a lump in her abdomen.

The history was that in 1934, nine months after her first pregnancy, she noticed a small painless lump, about the size of an ordinary hazel-nut, in the left side of her abdomen, near the umbilicus. The lump had grown steadily ever since. In July, 1937, a "short stabbing pain" which lasted for a fortnight was felt above the lump. Since then the pain had come on for a short time after her periods, which were regular. The lump was thought to increase in size during menstruation.

On examination the patient was healthy and normal except that there was a palpable lump in the abdomen, midway between the umbilicus and the left anterior superior iliac spine. It was not tender and was of pyriform shape, with its long axis parallel to the left inguinal ligament; it was 1 in. wide at its upper and outer end, $\frac{1}{2}$ in. wide at the other end, and $2\frac{1}{2}$ in. long. The swelling had a smooth surface, well-defined edges, was of hard consistency, and was mobile, but not freely so. On rectal examination the left ovary could be palpated apart from the tumour, and the uterus was small.

At operation the abdominal cavity was opened by a left lower paramedian incision, and all the contents found to be normal. The tumour could be palpated and seen projecting into the abdominal cavity from the anterior abdominal wall. Appendicectomy was performed and the abdomen closed. A $2\frac{1}{2}$ -in. incision was made over the long axis of the tumour. The external oblique muscle, which was not adherent to the lump, was divided in the direction of its fibres and retracted, showing the whitish tumour partly replacing and infiltrating the internal oblique and transversus muscles, the fascia transversalis and the parietal peritoneum. The internal oblique and transversus muscles were widely excised, removing the tumour together with the surrounding fascia transversalis and peritoneum, so that only tissues quite free from infiltration by the growth remained. The edges of the opening in the peritoneum were brought together easily. The transversus and internal oblique muscles were approximated less easily. The external oblique muscle, deep fascia and skin were repaired without difficulty.

Recovery was uneventful, and the patient was discharged as cured.

Pathological Report

The specimen consisted of a piece of tissue containing a firm mass 2.5 by 1.5 by 1.5 cm., traversed by many white strands and not distinctly separated from the surrounding tissues.

Microscopically the tumour was a cellular fibroma surrounded by degenerate striated muscle. There was no sharp line of demarcation between the tumour and the muscle, and the impression gained was that the former was irregularly infiltrating the latter (Fig. 1).

Within the depths of the tumour there was one distinct area of degenerate muscle (Fig. 2).

Conclusion.—The tumour has the characteristics of a true desmoid tumour.

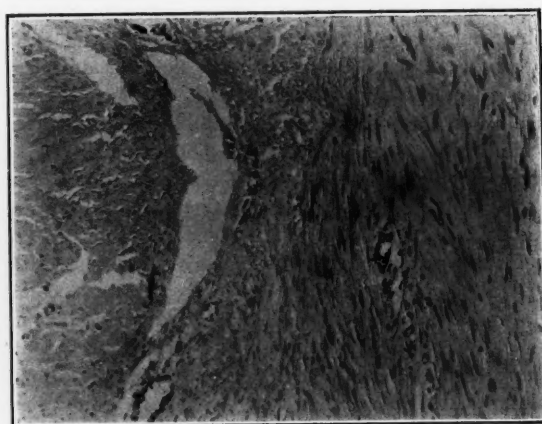


FIG. 1.—DESMOID (ON RIGHT) SHOWING ITS RELATION TO SURROUNDING MUSCLE. STAINED WITH HEMATOXYLIN AND EOSIN.

Nomenclature

In 1838 Johannes Müller first used the word "desmoid" to indicate tumours of a tendon-like consistency, but the term was not brought into general use until 1881–5 when Sänger used it in four papers.

Dr. Hughes Bennet first described the histology of these tumours, in 1849, as having "a peculiar structure consisting of filaments infiltrated with oval nuclei". In none of his three cases was the tumour on the abdominal wall, but they all recurred after the local excision and no metastases formed. He suggested the name "fibro-nucleated cancrioid growth", because "this peculiar tumour ought to be separated from true cancer on the one hand and fibrous growths on the other".

While lecturing to the Royal College of Surgeons, in 1851, Paget spoke of a tumour in the forearm of a boy formed at the site of a slight wound received at the age

of two, and renamed the growth "recurring fibroid tumour".

The term "desmoid" was limited to "fibromas arising in the musculo-aponeurotic structures of the abdominal walls" by Pfeiffer in 1904, and this definition has been generally accepted. Nichols does not agree with this regional limitation, and in his paper on 31 cases seen at the Mayo Clinic, 6 of which did not occur in the abdominal wall, he says: "They present similar clinical histories, and the clinical and pathological findings are such that one feels perfectly justified in classifying them as desmoids."

Treatment

The treatment of these uncommon tumours during the past century illustrates the great advances made in surgery over the period. Two cases of fibroma of the anterior abdominal wall were reported by Macfarlane in 1832. They were treated surgically, presumably without an anæsthetic. One of them died of peritonitis.

In 1856 a man, aged 27, "was admitted into Kenton's Ward" under the care of Mr. Paget. The patient "had a growth on the abdomen, just below the umbilicus for fourteen years, which had its origin in an injury to the front of the abdomen from a cart-wheel. Within the last two years the surface began to ulcerate, and the tumour has attained the size of a large flattened orange". On the only operating day for the week, "March 29th, the man was given chloroform, when Mr. Paget removed the growth by making a large semi-circular incision above and below it, and dissecting it off the sheath of the rectus, thus leaving a pretty large raw surface behind, a number of vessels requiring to be tied".

"April 17th.—The surface of the wound is cicatrizing over; oil dressing was used for the first three days, and water dressing afterwards, and he is going on as well as can be desired."

Whenever possible enucleation was practised, but the growths recurred again and again.

Suadicini first advocated that antiseptic operative precautions should be observed in treating these tumours. In his paper, published in 1875, he urges resection of the peritoneum where it has become infiltrated by the growth and reports a case treated in this manner.

Nichols, writing in 1923, naturally infers that aseptic operative principles should be followed, and says "Complete and early excision is the treatment of choice", while the application of "radium and Röntgen rays are excellent palliative measures in inoperable cases. He remarks, "radium was used post-operatively in most (of 31) instances but the benefit derived cannot be accurately estimated."

Theories

Theories concerning desmoids are in inverse proportion to the rarity of the growth. In 1860 Hugier put forward the extraordinary idea that these tumours arose from the fibrous periosteum of the pelvic bones and were always attached to it by a pedicle. Nélaton (1862) agreed with Hugier, but drew attention to the high percentage of cases that occurred in women who had borne children. He thought that congestion of the pelvic organs following conception and during menstruation was an important ætiological factor. Ebner (1880) and Hertzog (1883) enunciated the theory that desmoids resulted from muscular rupture, while Sängner (1884) thought they arose from the aponeurotic sheath



FIG. 2.—AREA OF DEGENERATE MUSCLE WITH HYPERCHROMATIC NUCLEI IN MIDDLE OF DESMOID. STAINED WITH HÆMATOXYLIN AND EOSIN.

of the abdominal muscles. Labbé and Remy (1888) considered that muscular rupture during the violent contractions of labour was the most common cause. Aime Guinard (1910) thought that true desmoids only occurred in women, usually in connection with the intraparietal portion of the round ligament. Cases occurring in men he dismissed as aponeurotic fibrosarcoma.

Nichols (1923) records eight cases that occurred in abdominal walls that contained operation scars, and in only four was the scar involved by the growth. He therefore concludes that as the "tumours were found in scars only four times in approximately 100,000 abdominal operations, their occurrence may be considered coincidence."

Stewart and Mouat (1924) agree with Labbé and Remy, and postulate an unknown predisposing factor to account for the rarity of the tumour. They report that it occurs most frequently in the third and fourth decades,

and consider "the analogy with keloid is a very close one . . . the points of difference being really dependent on their site in skin and muscle respectively". Of their 66 cases, 80% were in women who had borne children, and most of the remainder gave histories of injury or strain.

Conclusions

1. A desmoid is a fibroma usually occurring in the musculo-aponeurotic structures of the abdominal walls, but identical tumours also occur in connection with other muscles.

2. If untreated a desmoid will continue to grow slowly until it invades some vital structure. As it becomes bigger the central portion may break down and the rate of growth increase, but it does not form metastases.

3. The tumour may appear partly encapsulated when it is bounded by a fascial sheath, but elsewhere it will infiltrate surrounding structures. Characteristically the muscle adjacent to it is degenerate, and enclosed in the desmoid are degenerate muscle-fibres with hyperchromic nuclei. It is analogous to keloid.

4. Desmoids are caused by some unknown predisposing factor, together with trauma and stretching of the musculo-aponeurotic structures concerned. The most common factor is the physiological trauma of violent contractions during labour (80%, Stewart and Mouat).

5. Even when the predisposing factor is present the muscle may be incised without causing a tumour to be formed.

6. Clinically desmoids are rare, usually symptomless, slow-growing, often hard tumours occurring in muscle and aponeuroses, especially of the abdominal wall. They are difficult to diagnose clinically.

7. Treatment should be by wide excision while the tumour is still small. Inoperable cases can be treated with radium or X-rays.

8. If recurrence takes place, wide excision should be repeated. There is "no evidence that sarcomatous metamorphosis occurs" (Stewart and Mouat).

I thank Mr. John Hosford for his kind advice and permission to publish this case, and Dr. Magnus for allowing me to reproduce his pathological report.

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SMALLPOX:

SOME FURTHER OBSERVATIONS WITH SPECIAL REFERENCE TO THE FILTERABLE VIRUSES

By P. B. MELLOWES, M.R.C.S., L.R.C.P., D.P.H.

MY first reference must be to the editorial note at the end of April's article that since going to press one of the supposed influenza cases had proved to be true smallpox ; the possible deduction being that vaccination and the necessity for it, which I intended to be the keynote of that article, had failed in some essential measure.

On the contrary, Jenner's great legacy to mankind has proved to be of inestimable benefit to my afflicted colleague, as apart from the severe constitutional symptoms of the prodromal stage, experienced by all the so-called influenza cases who had been in contact with the smallpox patient from the "Cathay", he has suffered very little. His mild rash of typical variola distribution has cleared up without scarring, and he is now back on duty—an undoubted tribute to his past vaccinations.

It cannot be over-emphasized, however, that one lot of vaccination does not protect for ever, nor for that matter, does one get permanent immunity from an attack of smallpox.

Louis XIV of France died of a second attack of smallpox, and so did Queen Anne of England, I am told.

As regards other sequelæ, the author, who developed the so-called "influenza", in common with the acknowledged case of smallpox and the other four "flues", felt the effect of the neuro-toxins of the condition, the heart in particular protesting in no uncertain terms against climbing the pilot ladders of lightships. To round off his tale of woe he has subsequently had a good crop of facial herpes followed by wet eczema.

Dr. H. S. Banks, who kindly edited my previous effort and attended the case with me daily, took a month to recover, and like Dr. M. R. Lawrence, who wrote the most interesting letter published in the May edition of the JOURNAL, is certain that we suffered from a *variola sine eruptione*.

Bearing this out is the additional evidence that two medical inspectors from the Ministry of Health, who made an independent examination of the patient, and from start to finish had no contact with our medical officers, went down with the same trouble exactly seven days after their visit.

Other cases of smallpox which have occurred in Gravesend since the "Cathay" outbreak, whilst showing no evidence of direct contact, bring up the grave problem of the possibility of "carriers", who whilst not suffering themselves, somehow manage to convey the disease and carry on the strain after the recognized incubation is ended.

One, a building contractor, who lived in a house opposite to the engineer of our launch (one of the "flues"), was admitted to the Gravesend Isolation Hospital, 10 days after we landed a patient, suffering from indisputable variola. He made a successful recovery, the severity of the condition having been mitigated by positive vaccination in infancy.

At present there is still another serious case of confluent smallpox in Gravesend, whose history is of interest.

A man, æt. 60, dealer in such livestock as dogs and rabbits and a stallkeeper in the market, had been estranged from his daughter for some years, and hearing that she had been admitted to the isolation hospital and was dying, visited her and kissed her.

Fourteen days later he became ill and developed a typical variola rash.

The daughter, who was employed at a café on the waterfront frequented by seamen, had had a severe throat infection which developed into a septicæmia without a rash, and commenced 28 days after the landing of the "Cathay" case.

Taking into consideration that our knowledge of smallpox, with the exception of its prevention by vaccination, has not materially increased in the last 2000 years, and is still mostly hypothetical regarding its fomites and mode of spread, I venture to suggest with all hope of contradiction that there must be some connection between our case and the Gravesend ones.

The fact that every cog in the wheels of the preventive port health machinery has turned is manifest by the absence of any epidemic, but there must still be some factor unknown. It is of further interest to note that the infecting "bug", whatever it was, showed an overwhelming partiality for the male sex. Of all the contacts we would have thought that the Matron and Nurses of the Port Isolation Hospital looking after the original case would have succumbed, but fortunately they did not.

This brings me again to the possible association between our so-called influenza outbreaks and the fatal case of variola major, and introduces us into the unknown fairyland or jungle populated by the filterable viruses, or maybe to the resurrection of some "old-fashioned" discarded theories concerning the latter.

The remarks hereunder will appeal more probably to the epidemiologist than to the bacteriologist, and I

cannot claim authorship to all or take the responsibility for some of the statements. They are mostly the results of letters from and conversations with those who were interested by the first article, and have consented to my correlating their words of wisdom. In particular I have to thank the well-qualified observer and authority whom I mentioned before.

Whilst appreciating that much of the matter is highly controversial, it is with no wish to appear pedantic that I write on occasion in the assertative but merely for the sake of brevity.

The filterable viruses cause disease with relatively long incubation periods, or many of them do. Rabies up to 6 months and influenza the shortest, only 2 days. Yellow fever of 4 to 5 days only, due presumably to the intradermal route of infection. Measles and psittacosis the next, about 10 days. Smallpox usually 12, chickenpox and herpes about 18 days.

It is observed that there is also *B. psittacosis* of the Gaertner group. But it is not the causative organism any more than *B. influenza* is the causative organism of "flu"; they are merely associated and not invariably there.

The incubation period of approximately 7 days for our little "flu" epidemic upsets the normal 2 days' interval, as much as our contact variola case upsets the orthodox "12 days to the minute" for that complaint.

If the disease is of a very virulent type it means that the person who becomes infected gets a massive dose of poison, which acts more quickly than a diluted or moderate dose. For instance, we would die at once from 100x of HCN, but in an hour from 10j. The incubation period of water- or milk-borne enteric is roughly 14 to 21 days; but laboratory accidents and infections, where the dose is enormous, cause symptoms of enteric to develop the next day.

The mention of psittacosis brings me to some interesting observations. Some years ago before the Prohibition of Parrots Importation Act came into being, I had an African "grey" which died with all the signs and symptoms of what would appear to be in retrospect those of psittacosis, although unfortunately no bacteriological examination was made of the bird. Although I had handled the bird during its illness nothing amiss occurred to me, but within two weeks my immediate colleague, who had had no contact with the parrot whatsoever, developed and subsequently died of a mysterious illness (mainly enteritis and toxæmia), which was thought to be possibly a fungus poisoning, as he professed to be able to differentiate between the edible and inedible toadstools and ate some.

Now was I the "carrier" of a filterable virus, and had the bird developed its disease "*de novo*", as it

had not been in contact with any other bird for several months?

Accepting the transmutation of metals as an established fact, *e.g.* radium into lead, why not animal transference?

Could not parrots, having picked up some human virus, possibly "flu", pass it about amongst themselves until it became something virulent, in much the same way as oysters presumably persuade the ordinary harmless *B. coli* to become a virulent *B. typhosus*. No oyster sucks in the *B. typhosus* as such, because the viability of that very delicate bacillus is *nil* in strongly antiseptic sea-water, which accounts for the fact that *B. typhosus* has never yet been found in oysters, and presumably never will be.

For the sake of argument in this pseudo-scientific medley I am deliberately omitting the work of Klein, and placing reliance upon the fact that Sir Alexander Houston and his workers examined hundreds of thousands of samples of water and sewage, and millions of colonies without finding the bacillus.

If the agglutination tests on *B. coli* from sewage-infected oysters were made, however, some might be found to react.

It has been suggested that typhus with its incubation period of about 21 days is also due to a filtrable virus. The virus lives in the louse and in the eggs of the infected vermin, and although Noguchi found a spirochæte in the urine of typhus patients, that does not mean that the infection is passed by the spirochæte *as we know it*.

Spirochætes were found in the urine of trench-fever patients on the eighteenth day of illness; but the disease is louse-borne and filterable. Spirochætes were found in blood-films of trench fever patients. It is suggested, therefore, since we know typhus and trench fever are due to filterable viruses and that filtered blood from cases is infective, that the filterable viruses in these instances is part of the life-history of the protozoan spirochæte. If you observe *T. pallidum* by dark ground you see them slowing down, dying and breaking up into Brownian particles—filterable entities. He would be a brave man to say that because the spirochætes have disappeared from the hanging drops, that the remaining serum was not infected.

The filterable virus may be a minute spore stage of the plasmodium or protozoan which later develops into something invisible also or possibly visible, like Negri bodies in rabies and the so-called trachoma bodies or the spirochætes in typhus and trench fever. If the filterable viruses are life stages of protozoa, that would explain their long incubation period (but not "flu" unfortunately). Consider how varied are the symptoms caused by protozoal infections. Malaria, for example,

will simulate anything you like to think of, except perhaps a broken leg. Think too of the various ways in which ordinary influenza manifests itself—the catarrhal, the pulmonary, the intestinal, the suicidal, the paralytic (deltoids, poliomyelitis), Parkinson's syndrome (epidemiologically encephalitis lethargica is always due to influenza—Hippocrates about 400 B.C. noticed it—except those few rare cases in non-vaccinated adolescents which are definitely due to vaccination), and arthritic (with acute serous effusions into joints).

After all of which can any reader kindly supply any further solution to our recent illness, whether an influenza or *variola sine eruptione* (not forgetting the mixed grill of spirochætes and infiltrable viruses), including that hardy annual vaccinia or what?

ED. NOTE.—Since going to press a further fatal case of confluent smallpox has occurred at Gravesend. The deceased was an *unvaccinated* young woman of 23. She had been in contact with a fatal case of "influenza" exactly twelve days before her death.

SPORTS NEWS

DICTATORSHIP.

Rather a peculiar title for a Sports Editorial, but behind it lies food for thought. The secretary of any club is something of a dictator is he not? he commands the axes and rods of his own little province, and can do a lot for his club if he is the right kind of man, *and gets the right kind of support*.

The continuous plaint of these minor dictators is that their subjects are generally too keen on waiting until the day before a game before crossing their names off on the list of their team. This habit of waiting until one finds out whether anything better to do is going to turn up, is felt by secretaries to be, as Mr. McNeil Love would say, a diabolical form of practical joke strongly to be deprecated.

In return for the favour of prompt notice as to whether a member of a side intends to play, however, we feel that the members themselves deserve to know important details of their clubs, such as the scratching of matches.

We must be fair to our secretaries, and in return we can but expect the same treatment from them.

CRICKET NEWS

At the Annual General Meeting of the United Hospitals' Cricket Club, R. Heyland was elected Secretary for the forthcoming year.

The first match of the season was played at Chislehurst on Saturday, April 30th, against **U.C.S. Old Boys**. The table, although only in its first season, is in extremely good condition.

Our captain performed his duty well and the hospital batted first. The batting which is supposedly our strong point let us down badly, except for W. M. Maidlow's, who scored 30 in first rate style and J. E. Miller, who batted very solidly for his 18. The rest did nothing, and the innings closed for 88. To Bates went the honour of making the first duck on the new ground, and to him also went the honour of taking the first catch, an extremely fine one taken low down at cover to dismiss one of our opponent's opening pair.

Our bowlers bowled quite well considering it was the first match, especially Nicholson, who kept a good length, and finished with an analysis of 3 for 29. Our total, however, was passed for 6 wickets, and our opponents went on to make 137.

This would have been much larger but for the magnificent fielding of the whole side.

R. Heyland, b Drury	3
J. E. Miller, lbw, b Moran	18
J. North, b Glanfield	10
J. T. Robinson, b Moran	1
W. M. Maidlow, run out	30
C. T. A. James, run out	7
M. Bates, b Abrahams	0
C. G. Nicholson, b Abrahams	13

S. T. Rutherford, not out	1
G. A. S. Akeroyd, b Abrahams	0
B. G. Grettton-Watson, b Abrahams	0
Extras	5
Total	88

R. Heyland, b Bott	12
T. K. Whitmore, b Green	7
J. E. Miller, c Grundy, b Bott	9
R. N. Grant, b Green	0
J. North, lbw, b Bott	0
W. M. Maidlow, c Grundy, b Bott	12
C. G. Nicholson, not out	42

S. T. Rutherford, c Palmer, b Bott	7
B. G. Grettton-Watson, c Palmer, b Batson	9
J. Craig-Cochrane, not out	11
Extras	12
Total (for 8 wks.)	121

U.C.S. Old Boy, 137. C. G. Nicholson, 3 for 29; C. T. A. James, 1 for 20; J. T. Robinson, 3 for 37; S. T. Rutherford, 2 for 22.

Sunday, May 1st, v. **The Rabbits**, at Chislehurst. Won.

Bart.'s : 150 for 6 (declared). R. Heyland, 68; J. North, 36.

The Rabbits : 121. C. T. A. James, 4 for 25; B. G. Grettton-Watson, 4 for 45; J. T. Robinson, 1 for 19; M. J. Pleydell, 1 for 14.

Saturday, May 7th, v. **Brondesbury**. Away.

Unfortunately for this match we were unable to raise our strongest side and were woefully short of bowlers.

Brondesbury batted first, and their opening pair added 153 runs in a very unenterprising manner before one of them was caught by Robinson off Rutherford. They finally declared with the score at 205 for 4.

Our bowlers, particularly Evans, Rutherford, and Wells-Cole, after an erratic start, bowled quite well, but did not meet with much success.

We were left 2½ hours in which to get the runs, and Brown and Robinson gave us a good start by scoring 44 in quick time before Robinson was out for 18. Two more wickets then fell quickly, including that of Brown who had batted very well for his 30. However, while Maidlow and North were in there was still a chance of the runs being knocked up, but on North being bowled, and Maidlow foolishly running himself out a few minutes later, all hope of winning the game vanished. Out lower batsmen, particularly Evans (21) and Rutherford (13 not out), defended well, but to no avail, as Grettton-Watson, who had played stubbornly, was given out l.b.w. by their umpire on the fourth ball of the last over.

It was a very enjoyable game, and a great shame we could not raise a full side, as, had we been able to do so, I am certain we should have beaten them.

D. J. A. Brown, b Hornsby	30
J. T. Robinson, c Milton, b Martin	18
J. North, b Hornsby	14
M. Bates, lbw, b Martin	1
W. M. Maidlow, run out	19
G. H. Wells-Cole, c Milton, b Hornsby	10
J. W. G. Evans, c Barns, b Hornsby	21

M. Shrinagesh, b Cook	2
G. A. S. Akeroyd, c Martin, b Cook	6
S. T. Rutherford, not out	13
B. G. Grettton-Watson, lbw, b Hornsby	6
Extras	7
Total	147

Brondesbury, 205 for 4. S. T. Rutherford, 2 for 59 in 18 overs; J. W. G. Evans, 1 for 38.

Saturday, May 14th, at Chislehurst, v. **Hornsey**. Match drawn.

We were fortunate in this game in having almost our full side out. Cochrane and Grant, both playing in their first game of the season, opened our attack and bowled very well on a wicket which could be called nothing else but a batsman's paradise. Our other bowlers, especially Nicholson, who took 3 for 31, kept a perfect length, and was always doing something with the ball, and Grettton-Watson, who bowled his slow stuff with great cunning, and took 4 wickets; both bowled extremely well.

Our fielding was again very good, particularly in the case of Rutherford, who took a magnificent left-handed catch in the gully. We shall have a chance to compare him with England's best gully fielder for a long time when A. P. F. Chapman comes down to play against us for the M.C.C. on June 18th.

Our opponents declared at 188 for 9, leaving us plenty of time to get the runs, but our batting let us down badly, and thanks to a fine innings by Nicholson of 42 not out, and stubborn batting by Maidlow and Cochrane we were 121 for 8 wks. at the close of play.

When our batsmen start making runs, as they most certainly will soon, we shall have a good side, and should do well in the forthcoming Cup Matches.

G. A. S. Akeroyd did not bat.

Hornsey : 188 for 9 (dec.). R. N. Grant, 2 for 34; C. G. Nicholson, 3 for 31; B. G. Grettton-Watson, 4 for 73.

Sunday, May 15th, v. **Philanderers**. Won.

Bart.'s : 189 for 9 (dec.). W. M. Maidlow, 64 not out; C. G. Nicholson, 43.

Philanderers : 157. R. N. Grant, 5 for 38; C. G. Nicholson, 3 for 53.

Wednesday, May 18th, v. **R.M.C. XXII**. Away. Drawn.

Bart.'s : 239 for 9 (dec.). R. Heyland, 65; J. North, 60; C. T. A. James, 51 not out.

R.M.C. XXII : 188 for 8. R. N. Grant, 3 for 46; C. G. Nicholson, 2 for 53.

ATHLETIC CLUB

The Paris Trip.—Three of our members, Beck, Reinold and Ward were chosen to represent London University for their Annual fixture against Paris University, this year held in Paris. In spite of the many distractions, bottled and otherwise, our trio did very well. Reinold was first in the 110 metres hurdles, though a certain unsteadiness was noticeable at the last hurdle, Beck was second in the 1500 metres in fast time, and Ward was second in the long jump. The jump being measured in metres caused great speculation as to distance "in real figures", it eventually being decided that "it must have been pretty good". Later it was officially denied that Ward had cleared well over 210 feet.

The week-end, apart from the sports, was well spent, and Beck's fluent French (Honours Matric.), backed up by some mystic hand signs by Reinold, took us through some rather one-sided conversations with policemen and taxi-drivers, with fair credit.

Perhaps the most vivid incident was of Reinold laden with bags, coats, etc., producing a really fine turn of speed along the station platform, overtaking the moving Boulogne-Paris train hotly pursued by a rather noisy waiter. This unwelcome addition to our party was dropped (7-10 miles an hour) only after considerable French coin had changed hands.

Flushed with success, etc., the party reached Victoria at a late hour, where a reception committee headed by Mr. Kenneth Walker awaited.

SWIMMING CLUB

The day spoke fair as we bowled down to Cambridge, but better far the howling heath than the sunny road, better the three witches than the smiling potmen, to warn of the dread carnage awaiting in Cambridge. Still, remembering the fate of the mighty—

Sheen swam magnificently to beat the half-blue Garforth in the 220 yds. free style in a glorious 2 min. 38 sec., and later to gain second place in the quarter-mile. After that, a virtual University side (with one exception) swept the board, in spite of gallant, but rather untrained attempts by the socii.

In the Polo, the lack of cohesion was only rivalled by the obvious lack of training, very obvious after two to three races per individual.

Results :

220 yds.—Sheen (B.) 2.38 (1), Garforth (T.) 2.42 (2), Walley (B.) 2.47 (3).

440 yds.—F. B. Ball (T.) 5.59½ (1), Sheen (B.) 6.8 (2), Garforth (T.) 6.14 (3).

100 yds.—Manson (T.) 60 (1), Hill (T.) 64½ (2), Pratt (B.) 65.

60 yds.—Ivanovic (T.) 29½ (1), Culson (T.) 30 (2), Hoskyn (B.) 33 (3).

Medley Relay.—Tadpoles 2.3 (1), Bart.'s (Macafee, Pearce, Walley) 2.9 (2).

Free Relay.—Tadpoles 2.22½ (1), Bart.'s (Sheen, Hoskyn, Monckton, Pratt) 2.23 (2).

Points : Cambridge University Tadpoles 23, Bart.'s 11.

We pass over the Polo in silence, noting only that the Tadpoles, in fine fettle, won 6—0. In the evening it was decided by all to start

training by an intensive course of Dr. Dale's estimable local waters. We would also thank Pembroke for its charming hospitality.

Polo.—Greenberg, Monckton, Pratt, Walley, Hoskyn, Pearce, Macafee.

Oxford Dolphins

Undaunted, but shaken (to say the least) by the illness of Sheen and Monckton, we faced the ranks of Tuscany in Merton Street Baths. The day opened with a narrow win by the Secretary over Lodge, the Oxford Secretary. Then Coates, a newcomer to Charterhouse, swam a well-judged race to take the 220 yds., with Hoskyn ("Bone in the Teeth") taking an inspired third. In spite of this the match was lost 18—15.

The water polo was a shambles, we regret to say, being lost 10—0. The side blame the shallow bottom.

We were refreshed at the Philistines, refreshed at Balliol Buttery, and later visited such old world spots as the Turf—purely as sight-seers, *bien entendu*.

Results :

100 yds.—G. S. Stockwell (D.) 60½ (1), C. H. Kearney (D.) 63 (2), J. S. Pratt (B.) 64½ (3).

220 yds.—T. Coates (B.) 2.52 (1), S. C. Matthews (D.) 3.1 (2), C. H. Hoskyn (B.) 3.4 (3).

440 yds.—G. J. Walley (B.) 6.0½ (1), R. M. Lodge (D.) 6.0½ (2).

Free Relay.—O. U. Dolphins 1.44½ (1), Bart.'s 1.46 (2) (Pratt, Hoskyn, Pearce, Walley).

Polo.—Greenberg, Hoskyn, Macafee, Walley, Pearce, Pratt. Lost 10—0.

WATER POLO

In the 1st Hospital Cup Match some excellent practice was had in beating **Charing Cross** and **Royal Dental** 12—0. The scorers were Macafee 1, Hoskyn 1, Walley 2, Pearce 3, Pratt 3, McKane ("Veteran") 2, Greenberg in goal not being allowed to score.

In the 2nd Cup Match *v. Guy's*, some hard knocks were taken in achieving a 2—2 draw. Greenberg played a superb game, and was very unlucky to let the equalizer through after Bart.'s had led the whole way. McKane and Pratt were the scorers.

The team was Greenberg, Macafee, Hoskyn, Walley, Pearce, Pratt, McKane.

GOLF The Staff and Students mixed foursomes competition was held at Denham on March 26th. The weather was fine, and the course in excellent condition. Ten couples entered. The competition was won by Dr. Roxburgh and C. M. Fletcher, 35 points; second were Dr. G. Graham and R. S. Russell-Smith, 32 points.

The Staff *v.* Students match was played at Denham G.C. on May 18th. The course was very hard, the conditions rather showery. The Students conceded a handicap of 3 bisques in the singles and foursomes. The singles were won by the Staff 8—0, 4 matches being halved, the foursomes by 4—2. The Staff thus won the match by 12—2 points.

SAILING CLUB The St. Bart.'s Sailing Club Regatta, held on May 15th, was a great success. A fine sunny day with a nice breeze and occasional strong puffs made it a day of perfect sailing weather.

There was a muster of ten boats (J. Walley, arriving too late from Pin Mill to enter for the race, went for a good row around the Estuary!), and a course of 8 miles was chosen. Loughborough looked very worried before he ran his sail up.

The dinghies crossed the line almost simultaneously with a good "soldier's wind" over the quarter from the south; Thursby-Pelham took the weather berth. The boats kept very close together for the first 1½ miles to the Green Holliwell buoy, which Thursby-Pelham, White and Bentall left to starboard without mishap. The remaining seven boats were very close and rounded together, unfortunately Brady got into irons and finally capsized.

There was a fine exhibition of short tacking by White and Bentall up to the Roach Buoy.

Thursby-Pelham gave White a lee bow at the Branklet Buoy which failed to stop the latter, who passed and took the lead.

M. W. C. White finished first 1½ minutes ahead of A. Bentall, with Thursby-Pelham a good third by 40 seconds.

AN APOLOGY We regret that in the report of the Annual Inter-Firm Seven-a-side Competition published in last month's JOURNAL, the Dark Blue firm were put into the semi-final at the expense of the Pink, who were their victors in the first round, and we wish to apologise to all concerned.

CORRESPONDENCE

THE SPRING BOOK SUPPLEMENT

To the Editor, 'St. Bartholomew's Hospital Journal'.

DEAR SIR,—I have perused your Spring Book Supplement with misgivings, and perhaps I am voicing the views of some of your readers in saying that I am not sure that your policy will be generally approved.

It seems to me that the JOURNAL must aim at a very high level of criticism before so much space and attention can reasonably be bestowed upon the reviewing of medical books. Moreover, I find it difficult to believe that most readers of the JOURNAL are greatly interested in book reviews. The articles which appeal most are those which have little if any direct bearing on modern medicine, but which deal particularly with the giants of the past. If, however, the JOURNAL Committee decide to continue their policy of including a literary supplement, perhaps I may be allowed to offer a few suggestions, for I have done as much reviewing of medical books as most men of my age, and have felt the impact of criticism from reviewers myself.

The best reviews of scientific literature are to be found in *Nature*—which also has a literary supplement. But its important reviews are always signed, so that readers may know what reliability can be placed upon the opinions of the reviewer. I am afraid that many of us disagree with the policy of the popular medical journals in insisting that the reviews shall be anonymous. No decent-minded reviewer would think of levelling harsh criticisms anonymously, with the result that such reviews are insipid, and usually without critical value.

I do not wish to be unkind about your Supplement, but my personal opinion is that almost every one of the reviews is of poor quality. To obtain a good review the reviewer must be of the same academic distinction as the author. The greatest reviewer of all time was undoubtedly Macaulay, and perhaps the Editor of the JOURNAL might re-read Macaulay's *Historical Essays* to appreciate my point of view. Not that I am one of Macaulay's admirers. He was a terrible fellow, venomous and spiteful, with no conception of Christian charity, and it has always pained me to see his statue placed with that of Newton in Trinity Chapel. But Macaulay's erudition was stupendous, which made him so good as a reviewer. Of late I have taken a dislike to his English—having been brought up on it—and I think now that it compares most unfavourably with the lovely cadence of Gibbon. Take, for example, this quotation from Gibbon: "It was their favourite opinion (Gibbon is referring here to the early Christian fathers) that if Adam had preserved his obedience to the Creator, he would have lived for ever in a state of virgin purity, and that some harmless mode of vegetation might have peopled paradise with a race of innocent and immortal beings." Macaulay never approached this standard. Consider first the phrasing, with its suggestion of alliteration, the perfect vocabulary, and then ponder over the cynicism and the gentle irony of Gibbon himself. Macaulay could, however, with conspicuous ability hide his clumsy articulation under an impressive weight of historical facts. Please do not think that I have chosen one of Gibbon's most famous passages, for it is easy to find comparable sentences on almost every page of the *Decline and Fall*. I do not wish to maintain that such a high literary standard should be insisted upon by the Journal Committee. It might be worth consideration, however, to ask for modest literary distinction from the JOURNAL reviewers if a Supplement is to be included.

Next, I may perhaps be pardoned for intruding some personal experiences. I want to acknowledge the kindness and courtesy of the reviewer of my book in the JOURNAL, but most authors crave for constructive criticism. If the review is signed, the reviewer can give full rein to his critical faculties, and his readers, knowing him, can themselves assess how much weight should be attached to his opinions. This is perhaps an opportunity of asking your readers to peruse the *Journal of Obstetrics and Gynaecology of the British Empire*, wherein they will find, amongst some most interesting material, an admirable review by Prof. Strachan, teeming with good criticism, and most valuable to me myself. If your readers are sufficiently astute they will learn, mark and inwardly digest the personal leg-pulling, which is the hallmark of a good review.

In conclusion there are two things I want to say. First, provocation is—to some people—the spice of life, which sounds rather like the B.B.C. Next, people who live in glass houses should not throw stones, and according to Newton's third law, to every action there is

an equal and opposite reaction. I am therefore not unmindful of possible repercussions, and even of a little *vis a tergo*.

Yours, etc.,

WILFRED SHAW.

109, Harley Street, W. 1;
May 18th, 1938.

[ED. NOTE.—Criticism as outspoken as that of Dr. Wilfred Shaw is always worth hearing.

We join him in condemning the mealy-mouthed reviewer, for he is both a pest and a bore. But whether a man who signs his review will be any bolder than his anonymous brother appears to us doubtful. Further, if reviews are to be signed, we must be certain of a brisk supply of gynaecological giants, with literary leanings, of course, to review the works of authors so eminent as Dr. Shaw.]

REVIEWS

SEX AND THE ADRENALS

The Adrenal Cortex and Intersexuality. By L. R. BROSTER, CLIFFORD ALLEN, H. W. C. VINES *et alia*. With a foreword by Sir WALTER LANGDON-BROWN. (London: Chapman & Hall, Ltd.) Pp. 245. Illustrated. Price 15s.

In this volume have been published together a series of articles on one of the newest and most controversial aspects of endocrinology. When Dr. Vines demonstrated the presence of the fuchsinophil cell in the adrenal cortex by means of the ponceau-fuchsin stain he could not have imagined the amazing paths along which this single concrete fact was to lead him and his co-workers. By virtue of this it was possible to demonstrate the androgenic phase in the development of the fetal adrenal of both male and female leading, mainly in the latter instance, to an instability which was to result in such important physical and psychological changes in pre- and post-pubertal life. In addition, it was possible to show that the adrenal cortex is a potentially bisexual accessory sex-gland from the earliest stages of its development, probably under pituitary control, and capable of simultaneous elaboration of both androgen and oestrogen, one or other being in excess.

The book is admirably divided into two main parts, the Clinical and the Scientific Study of the Adrenogenital Syndrome. The first is in two smaller sections in which the surgical and the psychological angles are discussed. The histories of nearly one hundred cases are quoted in detail, and numerous photographs lend emphasis to the extremely lucid reports. This section, which includes the technique of adrenalectomy, is expertly handled by Mr. Broster. Dr. Clifford Allen deals carefully and lucidly with the profound psychological problems involved and discusses the psychical sexual pattern and its reinforcement by the sex hormones, and *vice versa*.

In the second half of the book Dr. Vines expounds the pathological side, and it is rare indeed that one reads so masterly and lucid an exposition of any scientific study. It is a calm and calculating estimation of the facts, and the author permits himself no liberties. Patterson and Greenwood collaborate on the first section of the biochemical study, and Prof. Marrian, of Toronto, and his associate, Butler, report on the new hormone, pregnane 3-17-20 triol ($C_{27}H_{48}O_3$), which they have succeeded in isolating from urines of typical virilism cases. But on this it is too early to make further comment.

It is, in Sir Walter Langdon-Brown's words, the combined attack by medical, surgical, psychological, histological and biochemical methods which gives this research its peculiar value. The book is essentially one for the specialist, but its logical arrangement and clarity of expression should make a wide appeal to practitioners and students who are conscious of the profound clinical, psychological and social questions to which it draws attention. Much of it is theory; much of it is fact. But to express the spirit in which it was published Allen writes, "all that we can do is to build as solidly as we can, and hope that those who follow shall find even the ruins of our theories worthy foundations for their own edifices".

PHARMACOLOGY

Poulsson's Text-book of Pharmacology and Therapeutics.

Second English Edition thoroughly revised by STANLEY ALSTEAD, M.D. Liverp., M.R.C.P. Lond. (London: Wm. Heinemann, Ltd., 1938.) Pp. 557. 25s.

This second edition of Poulsson's work on pharmacology has been revised for the second time. In the introduction there is a long discussion concerning the classification of drugs. The various classifications hitherto used, the natural-order classification, the chemical classification and the therapeutic classification are discussed and discarded. The author divides the drugs under the following particular sections: (1) Organic remedies acting specifically after absorption; (2) organic remedies acting locally; (3) salts of light metals, alkalis, acids, halogens, oxidizing media, etc.; (4) heavy metals; (5) ferments and foodstuffs; (6) antitoxins and bacterial products. Perusal of the book indicates that the descriptions of the preparations and of the pharmacological and toxicological actions of the drugs described are complete and adequate. The historical details are good; for example, mention is made of the introduction of potassium iodide by Wallace in 1836. As a book of reference, therefore, most of the essential available facts concerning pharmacology and therapeutics are to be found in this work.

Certain points of commission and omission can be lightly indicated. Why, for instance, is barium placed amongst salts of light metals? Why is sulphonamide placed among the sera on p. 535? The action of quinidine sulphate as a depressant of cardiac muscle is not sufficiently stressed, seeing that this is one of the dangers in its use in full therapeutic doses. The use of sodium chloride for Addison's disease is mentioned on p. 358, but there is no indication of the dosage required. The use of calcium chloride intravenously as a therapeutic or a diagnostic agent in spasm of, for instance, the bile-ducts, is omitted. There is no statement that iodine, as in Lugol's solution, is used orally in cases of Graves's disease.

Certain more serious criticisms must, however, be made. On p. 372 thirty-eight lines are given up to the use of the alkaline carbonates in the treatment of gout and uric acid, whereas the use of these alkaline salts in urinary infections is given four lines, and there is no mention of the almost specific action of their use in the acute pyelitis of children. There are traces that the revision has not in all particulars been brought carefully up-to-date, as is shown by the following examples: "Lauda Brunton recommends Calcium Chloride as a heart tonic" is written in all seriousness on p. 391, and on p. 132 the following sentence is found: "Fresh reports of poisoning cases, and fresh confirmation (Power and Tutin, 1905) of the old statement that Fool's Parsley contains an alkaloid-like conine make it imperative . . ." Another serious criticism is the amazing wealth of abstruse botanical information regarding pharmacological actions of rare plants, a subject of more use to a pure toxicologist than to a medical student. Taking the letter A of the index the following is an incomplete list of such plants and substances: *Anacardium occidentale*, *Anamyrta coculus*, *Absinthe*, *Acidum camphoricum*, *Adonidin*, *Adoxa moschatellina*, *Agrostemma githago*. A further statement which is surely not worthy of a serious scientific work is found on p. 384, "According to manufacturers' statements Allylthiocarbamide or Thiosinamine, when injected hypodermically, possesses the remarkable power of removing, or causing the absorption of cicatrices, no matter what their position may be". It is for these reasons that the book is in many respects not one that can be recommended to students as a handbook, although to specialists in the subject, or to others wishing to obtain help in regard to abstruse or unusual facts, it is likely to be a useful book of reference.

A Concise Pharmacology. By F. G. HOBART, Ph.C., and G. MELTON, M.D., M.R.C.P. (Leonard Hill, Ltd.) Price 7s. 6d.

The joint authors of this little book, one a pharmacist, the other a clinician, have aimed at producing a book of conveniently small size, dealing with the action of drugs in relation to practical therapeutics. While no attempt has been made at an exhaustive and systematic account of pharmacological action, those actions of clinical importance are concisely but fully treated. Of particular merit is the inclusion of proprietary names, placed after, and clearly distinguished from the official name. This is a useful step in the attempt to clear up the confusion which so often arises from the indiscriminate use of proprietary names as alternatives for the official ones. At the end of the book is a useful note on drug idiosyncrasy, with a list of the best-known examples, and the symptoms produced in each case.

Pre-eminently practical in character, this is not a book for the pre-clinical student. It should, however, be of great service to those working both in medical and surgical wards, in understanding the rationale of the use of drugs, and in the interpretation of the "blue boards", so liable to be neglected.

GYNÆCOLOGY

Diseases of Women. By Ten Teachers. Edited by CLIFFORD WHITE, Sir COMYNS BERKELEY and FRANK COOK. Sixth edition. (London: Edward Arnold & Co., 1938.) Pp. xii + 492. With 7 coloured plates and 158 figures. Price 18s.

It is with pleasure that we have to report another edition of this excellent text-book, which has achieved well-deserved popularity in past editions.

A number of changes in the editorial personnel have occurred, and we regret that Sir Comyns Berkeley has vacated the Directorship which he has held since the first edition of this volume and of its companion—*Midwifery by Ten Teachers*. He remains, however, as an editor. Messrs. Dodds, Stevens and Dr. Fairbairn, who were among the original Ten Teachers, have also retired, their places being taken by Messrs. Goodwin, Gilliatt and Wrigley.

The book has undergone very careful revision so that, although there are many authors, there is practically speaking no repetition. Fresh sections have been introduced or greatly modified, notably the Physiology and Disorders of Menstruation, and Methods of Contraception and Sterilization.

We can recommend this book without reservation. It represents one of the most authoritative and considered statements of the practice of gynaecology to-day. Complaints are heard from students of variations in the teaching in hospital practice contrasted with that expected at some examinations. This book may well rectify the position. The Ten Teachers of this volume not only represent the leading gynaecologists of the day, but also are past or present examiners for the Conjoint Board in England and for the London and Provincial Universities. As such it is of great value to the student.

EXAMINATIONS, ETC.

UNIVERSITY OF CAMBRIDGE

The following Degrees have been conferred:

M.Chir.—Ghey, P. H. R.

M.D.—Smart, J.

M.B., B.Chir.—Dorrell, E. W., Ward, J. H.

M.B.—Parks, J. W.

ROYAL COLLEGE OF PHYSICIANS

The following Members have been elected **Fellows**:

Chopra, R. N., Elgood, C. L., Martin, P. H., Moll, H. H., Nicol, W. D.

The following have been admitted **Members**:

Christie, R. V., Clarke, R. F., Latter, K. A., Levick, R. E. K.

CONJOINT EXAMINATION BOARD

Final Examination, April, 1938

The following students have completed the Examinations for the Diplomas of M.R.C.S., L.R.C.P., and have had the Diplomas conferred on them:

Bacon, A. H., Barker, J. E., Burnham Slipper, C. N., Cunningham, A. G., Dunn, D. M., Ellis, G. H., Fagg, C. G., Frazer, A. L., Halford, R. B., Harmer, M. H., Henderson, J. L., Jackson, K. V., Jamieson, J. G., Knowles, H., McMahon, R. J. H., Marshall, A. G., Morris, D. S., Porter, A. S., Stone, S. D.

SOCIETY OF APOTHECARIES OF LONDON

Final Examination

Surgery.—Bird, G. E. N., Gregory, J. C.

Medicine.—Stewart, E. F. G., Young, G. L.

Forensic Medicine.—Stewart, E. F. G., Young, G. L.

Midwifery.—Bird, G. E. N.

The Diploma of the Society has been conferred on: Bird, G. E. N., Young, G. L.

CHANGES OF ADDRESS

BEVAN, F. A., The Corner House, High Street, Woodstock. (Tel. 52.)

LANGSTON, H. H., (Professional) Morland Clinics, Alton. (Tel. 3333.) (Private) The Four Winds, Windmill Hill, Alton. (Tel. 3265.)

SLOT, GERALD, 2, Harley Street, W. 1. (Tel. Langham 1094.)

BIRTHS

ABERCROMBIE.—On May 23rd, 1938, at 76, Fitzjohn's Avenue, Hampstead, to Marie, wife of G. F. Abercrombie, M.A., M.D.—a daughter.

BAMFORD.—On April 27th, 1938, at 40, St. Mary's Street, Ely, Cambs, to Mollie (*née* Leeming), wife of Dr. Brian Bamford—a son.

DEBENHAM.—On April 10th, 1938, at 8, Addison Road, W. 14, to Mollie, wife of Dr. Gilbert Debenham—a son.

KNOX.—On April 27th, 1938, at Manor House, St. John's Wood Park, Hampstead, to Lynda (*née* Crust), wife of Dr. Robert Knox—a daughter.

PETERS.—On April 26th, 1938, at 41, Wimpole Street, W. 1, to Margaret, wife of E. A. Peters, M.D., F.R.C.S.—a daughter.

WARD.—On April 29th, 1938, at Roefield, Croxley Green, to Roy and Marjorie Ward—a daughter.

WHITBY.—On April 26th, 1938, at Old Bridge House, Datchet, to Mary Ellen (*née* Hurley), wife of Morton Whitby, surgeon, 7, Harley Street, W. 1—a son.

WOOD-SMITH.—On May 19th, 1938, at a London nursing home, to Joan (*née* Loane), wife of Dr. F. G. Wood-Smith, 2, Ashley Place, S.W. 1—a daughter.

WROTH.—On May 2nd, 1938, at 45, Southernhay West, Exeter, to Violet (*née* Jenour), wife of Charles Wroth—a daughter.

DEATHS

BAKER.—On May 4th, 1938, in India, Francis John Shearsmith Baker, M.R.C.S., L.R.C.P., aged 27.

BENNETT.—On May 21st, 1938, Colonel Vivian Boase Bennett, F.R.C.S., I.M.S. (retired), of Castletown, Isle of Man.

CROSS.—On April 23rd, 1938, Henry Wingfield Cross, of 12, Gwydyr Mansions, Hove, Sussex, eldest son of the late William Henry Cross, J.P., Clerk to the Governors of St. Bartholomew's Hospital, in his 69th year.

FURNIVALL.—On May 3rd, 1938, at Fernvale, Northam, North Devon, Percy Furnivall, Consulting Surgeon to the London Hospital, aged 71.

LLOYD.—On May 12th, 1938, at his home, 49, Alma Road, Windsor, Dr. William Frederick Lloyd.

MONTFORD.—On April 23rd, 1938, at New Street House, Upton-on-Severn, James Montford, M.R.C.S., L.R.C.P.

PROVIS.—On May 2nd, 1938, at Brighton, Francis Lionel Provis, F.R.C.S. (Edin.), youngest son of the late Dr. Wilton Provis, aged 65.

STARK.—On April 19th, 1938, at the Royal Northern Hospital, Harry Stark, M.R.C.S., L.R.C.P., of 26, Stoke Newington Common, N. 16, aged 33.

STOCKER.—On April 26th, 1938, Dr. Edward Gaved Stocker (Major, T.D.), R.A.M.C., elder son of the late Thomas Stocker, of Glenview, St. Austell.

SURRIDGE.—On Easter Day, 1938, at Wenden, Saffron Walden, Edward Ernest North Surridge, M.B., B.Ch., aged 73.

UNDERWOOD.—On April 29th, 1938, at his residence, "Algore," Felstead, Essex, Arthur Cresce Underwood, M.R.C.S., L.R.C.P., aged 66.

WALTON.—On May 4th, 1938, at Olinda, Knoll Road, Godalming, Lt.-Col. H. J. Walton, M.D., F.R.C.S., I.M.S. (retired).